

Comprehensive State Plan

2006-2012

**Virginia Department of Mental Health,
Mental Retardation and Substance Abuse
Services**

December 7, 2005

Comprehensive State Plan

2006-2012

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Comprehensive State Plan 2006-2012

Executive Summary

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services has developed the Comprehensive State Plan 2006-2012 to fulfill its statutory responsibility under § 37.2-315 of the *Code of Virginia* to produce and biennially update a six-year plan for mental health, mental retardation, and substance abuse services. This plan must identify services and supports needs of persons with mental illnesses, mental retardation, or substance use disorders across Virginia, resource requirements, and strategies to address these needs.

Services System Overview: Title 37.2 of the *Code of Virginia* establishes the Department as the state authority for mental health, and mental retardation, and substance abuse services. The mission of the Department's central office is to provide leadership and service to improve Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, mental retardation, or substance use disorders (alcohol and other drug dependence or abuse). The central office seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals.

Virginia's public services system includes 16 state facilities and 39 community services boards and one behavioral health authority (referred to as CSBs). CSBs are established by local governments and are responsible for delivering community-based mental health, mental retardation, and substance abuse services, either directly or through contracts with private providers. They are single points of entry into publicly funded mental health, mental retardation, and substance abuse services, with responsibility and authority for assessing individual needs, accessing a comprehensive array of services and supports, and managing state-controlled funds for community-based services. In FY 2004:

109,175 persons received mental health services,
23,925 received mental retardation services, and
53,854 received substance abuse services provided through CSBs.

These are unduplicated numbers of individuals receiving services in each program area. In FY 2004, for the first time, a totally unduplicated count of individuals receiving CSB services across the three program areas was available – 167,096 individuals received services from the CSBs.

The 16 state facilities provide highly structured intensive inpatient treatment and habilitation services. Current operating bed capacities are 1,686 for state hospitals (excluding the Hiram Davis Medical Center, with an operating capacity of 74 beds and the Virginia Center for Behavioral Rehabilitation with an operating capacity of 36 beds) and 1,629 for mental retardation training centers.

Service System Funding: FY 2004 funding for Virginia's publicly-funded services system from all sources, including the Department's final adjusted appropriation, local matching funds, all fees, and Medicaid MR Waiver payments to private vendors totaled \$1.36 billion, of which

\$838.7 million (62 percent) was allocated to CSBs,
\$493.5 million (38 percent) was allocated to state facilities, and
\$26.2 million (2 percent) was allocated to the Department's central office.

Estimated Prevalence: By applying prevalence rates from national epidemiological studies and the 2002 and 2003 National Household Surveys on Drug Use and Health to 2003 Final Estimated Population data, the Department estimates that:

Approximately 298,246 Virginia adults have had a serious mental illness at any time during the past year.

Between 92,346 and 110,815 Virginia children and adolescents have a serious emotional disturbance, with between 55,407 and 73,877 exhibiting extreme impairment.

Approximately 67,477 Virginians (age 6 and older) have mental retardation and 18,116 infants, toddlers, and young children (birth to age 5) have developmental delays requiring early intervention services.

Approximately 185,869 Virginia adults and adolescents (age 12 and older) abuse or are dependent on any illicit drug, with 122,072 meeting the criterion for dependence, and 449,644 adults and adolescents abuse or are dependent on alcohol, with 213,473 meeting the criterion for dependence.

Only a portion of persons with diagnosable disorders will need services at any given time and an even smaller portion will require or seek services from the public sector.

Service Needs: Numbers of individuals who were on CSB waiting lists for community mental health, mental retardation, or substance abuse services during the first three months of 2005 follow. These numbers are conservative because the point-in-time methodology used to compile CSB waiting lists does not identify the number of persons who needed services during a year.

Numbers of Individuals on CSB Waiting Lists for Mental Health, Mental Retardation, and Substance Abuse Services: January Through April 2005

Populations	Total Numbers on Waiting Lists
CSB Mental Health Waiting List Count	
Adults with a Serious Mental Illnesses	4,365
Children and Adolescents With or At Risk of Serious Emotional Disturbance	2,002
Total MH	6,367
CSB Mental Retardation Waiting List Count	
Individuals on CSB Waiting Lists for MR Waiver and Non-Waiver Services	5,174
CSB Substance Abuse Waiting List Count	
Adults with Substance Use Disorders	2,992
Adolescents with Substance Use Disorders	397
Total SA	3,389
Total CSB Mental Health, Mental Retardation, and Substance Abuse Services Waiting List Count	
Grand Total on All CSB Waiting Lists	14,930

Vision for the Mental Health, Mental Retardation, and Substance Abuse Services System:

The Department is committed to implementing the vision “of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of individual participation in all aspects of community life,

including work, school, family and other meaningful relationships” (State Board Policy 1036 (SYS) 05-3).

Integrated Strategic Plan Priorities: The Department’s Integrated Strategic Plan (ISP), *Envision the Possibilities: An Integrated Strategic Plan for Virginia’s Mental Health, Mental Retardation, and Substance Abuse Services System*, (2005) provides a framework for transforming Virginia’s publicly funded mental health, mental retardation, and substance abuse services system to:

- Fully implement self-determination, empowerment, recovery, resilience, and person-centered core values at all levels of the system through policies and practices that reflect the unique circumstances of individuals with one or more of the following: mental illnesses, mental retardation, or substance abuse disorders.
- Incorporate the principles of inclusion, participation, and partnerships into daily operations at all levels.
- Expand services and supports options needed to support individual and family choice, community integration, and independent living.
- Provide sufficient capacity to meet growing individual needs so that individuals with mental illnesses, mental retardation, or substance use disorders, wherever they live in Virginia:
 - Receive the levels of services and supports they need,
 - When and where they need them,
 - In appropriate amounts, and
 - For appropriate durations.
- Promote the health of individuals receiving services, families, and communities.
- Increase opportunities for collaboration among state and community agencies.
- Align administrative, funding, and organizational processes to make it easier for individuals and families to obtain the services and supports they need.
- Monitor performance and measure outcomes to demonstrate that services and supports are appropriate and effective, promote services system improvement, and consistently report on the transformation process.
- Provide stewardship and wise use of system resources, including funding, human resources, and capital infrastructure, to assure that services and supports are delivered in a manner that is efficient, cost-effective, and consistent with evidence-based and best practices.

Services System Transformation Critical Success Factors: Seven critical success factors are required to transform the current services system’s “crisis-response” orientation to one that provides incentives and rewards for implementing the vision of a recovery and resilience-oriented and person-centered system of services and supports driven by individuals receiving services and supports. Successful achievement of these critical success factors will require the support and collective ownership of all system stakeholders.

1. Virginia successfully implements a recovery and resilience-oriented and person-centered system of services and supports.
2. Publicly funded services and supports that meet growing mental health, mental retardation, and substance abuse services needs are available and accessible across Virginia.

3. Funding incentives and practices support and sustain quality care focused on individuals receiving services and supports, promote innovation, and assure efficiency and cost-effectiveness.
4. State facility and community infrastructure and technology efficiently and appropriately meet the needs of individuals receiving services and supports.
5. A competent and well-trained mental health, mental retardation, and substance abuse services system workforce provides needed services and supports.
6. Effective service delivery and utilization management assures that individuals and their families receive services and supports that are appropriate to their needs.
7. Services and supports meet the highest standards of quality and accountability.

Comprehensive State Plan Critical Issues and Strategic Directions: The Comprehensive State Plan describes critical issues facing the Commonwealth and includes goals, objectives, and action steps to achieve the following strategic directions.

A. Transforming Virginia's System of Care

Implement a recovery and resilience-oriented and person-centered system of services and supports.

B. Implementation of Self-Advocacy, Self-Determination, Recovery, Resilience, and Person-Centered Principles and Practices

Increase opportunities for individual and family involvement, education, and training.

Implement mental health programs that foster empowerment, peer support, and recovery-based services.

Enable individuals and families to determine the types of mental retardation services and supports they receive.

Reduce the stigma and shame associated with substance abuse.

C. Access to Services and Supports That Meet Individual Needs

Implement Olmstead Task Force Report recommendations related to the mental health, mental retardation, and substance abuse services system.

Establish an integrated system of service delivery for children and adolescents and their families.

Develop specialized services and supports for elderly persons with mental and substance use disorders.

Intervene and divert individuals with mental illnesses and substance use disorders from the criminal justice system, using a community-focused program model.

Provide individualized treatment services in a secure environment to individuals civilly committed to the Department as sexually violent predators.

Provide appropriate quality services to individuals with co-occurring mental retardation and mental illnesses, mental illnesses and substance use disorders, and services system individuals who also are deaf, hard of hearing, or deaf-blind.

Provide quality services when and where they are needed, in appropriate amounts, and for appropriate durations.

Implement evidence-based practices.

Implement the MR Services and Supports by Level of Care Options model.

Provide quality treatment, habilitation and rehabilitation, medical, and pharmacy services in state hospitals and training centers and share state facility medical and clinical expertise with CSBs.

Implement prevention initiatives, reduce the incidence and prevalence of suicide, and reduce youth access to tobacco products.

Prepare for and provide immediate, effective, and coordinated response to terrorism-related and other major disasters.

D. Partnerships for Services System Transformation

Expand Medicaid funding for community mental health, mental retardation, and substance abuse services.

Provide needed services to increase the stability of individuals receiving TANF benefits or involved in protective services.

Provide safe and affordable housing that meets the needs of individuals receiving mental health, mental retardation, or substance abuse services.

Improve the physical health and wellness of individuals receiving mental health, mental retardation, or substance abuse services.

Reduce barriers to employment and improve competitive employment opportunities and outcomes.

Encourage private provider participation in the services system.

E. Infrastructure and Technology

Assure state facility capital infrastructure is safe, appropriate for the provision of current service methods, and efficient to operate.

Enhance the capability of the services system to manage information efficiently.

F. Human Resources Management and Development

Address systemic workforce issues facing the services system.

Assure a competent and well-trained services system workforce with appropriate skills and evidence-based knowledge.

G. Service Quality and Accountability

Oversee quality of care and protection of individuals receiving services licensed by the Department.

Implement a high quality, effective, efficient, and responsive human rights system.

Enhance the quality of state facility treatment, care, and clinical services through uniform clinical guidelines and a system of Just Culture.

Implement a comprehensive and system-wide approach to utilization review and management.

Promote the use by state facilities and CSBs of research that advances quality treatment and improves clinical outcomes.

Improve medication management in community and state facility services.

Reduce seclusion and behavioral restraint in state facilities.

Resource Requirements:

Resource Requirement	FY 2007		FY 2008	
	SGF	NGF	SGF	NGF
MR Services System Transformation	\$89,966,700	\$69,548,900	\$103,073,000	\$74,548,900
MH Services System Transformation	\$32,621,500		\$35,450,000	
Unmet Community MR Services Needs	\$10,298,400		\$21,214,700	
Early Intervention/Part C	\$4,348,400		\$11,161,300	
SA Services System Transformation	\$22,107,000		\$25,543,300	
Direct Service Associate Salary Alignment and Competency Development	\$4,008,376		\$4,747,378	
Unmet Community MH Services Needs	\$7,434,300		\$15,314,600	
Unmet Community SA Services Needs	\$1,090,400		\$2,246,300	
Inpatient Pharmacy	\$4,344,996		\$5,055,679	
Medication Management System Procurement	\$4,410,844		\$611,474	
Licensing Staff	\$213,904	\$34,224	\$408,488	\$65,965
Central Office System Transformation Leadership	\$1,264,841		\$1,496,311	
State Facility Equipment Replacement	\$7,668,387			
Community Services (Aftercare) Pharmacy	\$2,107,877		\$3,858,691	
Regional Support Centers	\$500,000		\$500,000	
Behavioral Health Regional Health Information System (RHIO) Project	\$400,000		\$400,000	
Public Academic Partnerships	\$448,600		\$448,600	
Human Rights Centralized Call Center and Staffing	\$196,606		\$186,606	
Data Integration Project	\$288,176		\$198,960	
Architecture and Engineering Staffing	\$285,541		\$285,541	
VCBR Staff Salary Adjustment	\$41,951		\$41,951	
Special Olympics	\$120,000		\$120,000	
TOTAL	\$194,201,027	\$69,583,124	\$232,428,844	\$74,614,864

Notes: Non-general funds include anticipated federal Medicaid and Title IV-E funds.

Conclusion: The directions established in the *Comprehensive State Plan for 2006-2012* would enable the Commonwealth to accelerate the transformation of the public services system to a more completely community-based system of care while preserving the important service responsibilities of state hospitals and training centers. The policy agenda for the next biennium continues to focus, to the extent possible, on sustaining the progress that has been achieved

during the past four years in implementing the vision for the future mental health, mental retardation, and substance abuse services system and investing in services capacity and infrastructure needed to address issues facing the services system.

Comprehensive State Plan

2006 - 2012

I. INTRODUCTION

Section 37.2-315 of the *Code of Virginia* requires the Department of Mental Health, Mental Retardation and Substance Abuse Services (the Department) to develop and update biennially a six-year Comprehensive State Plan for mental health, mental retardation, and substance abuse services. This plan must identify the services and supports needs of persons with mental illnesses, mental retardation, or substance use disorders across Virginia; define resource requirements; and propose strategies to address these needs. That *Code* section also requires that the plan be used in the preparation of the Department's biennium budget submission to the Governor.

The Department's initial Comprehensive State Plan for 1985-1990 proposed a "responsible transition" to a community-based system of services. In 1986, the plan was expanded to cover a six-year time frame, with updates corresponding to the Department's biennium budget submissions. These updates continued until 1995, when agency strategic planning efforts replaced the 1996-2002 Comprehensive State Plan. Biennial updates to the Comprehensive State Plan were reinstated in 1997 with the completion of the 1998-2004 Plan.

The Department's Comprehensive State Plan has evolved to serve a number of purposes. The plan:

- Establishes services system priorities and future system directions for the public mental health, mental retardation, and substance abuse services system;
- Describes strategic responses to major issues facing the services system;
- Identifies priority service needs;
- Defines resource requirements and proposes initiatives to respond to these requirements; and
- Integrates the agency's strategic and budget planning activities.

The 2000-2006 Comprehensive State Plan introduced an individualized database to document service needs and characteristics of individuals on community services board (CSB) waiting lists have documented community service needs for the 2002-2008, 2004-2010, and the 2006-2012 plan updates. CSB waiting lists include individuals who have sought but are not receiving CSB services and current recipients of CSB services who are not receiving the types or amounts of services that CSB staff have determined they need. The CSB waiting list database provides demographic and service need information about each individual identified as needing community services or supports. Also included in the database are the CSBs' average wait times for accessing specific types of services and prevention service priorities.

In addition to CSB waiting list information, the Department surveyed state facilities to identify individuals who are on their "ready for discharge" lists. These include patients in state hospitals whose discharges have been delayed due to extraordinary barriers and residents of state training centers who, with their authorized representative or family member, have chosen to continue their training and habilitation in the community instead of at a training center.

The 2006-2012 Comprehensive State Plan incorporates the work of the Department's Integrated Strategic Plan (ISP), and is reflected in the Agency Strategic Plan (ASP) and associated Service Area Plans prepared as part of the 2006-2008 biennium budget submission to the Department of Planning and Budget.

The ISP is the product of a two-year strategic planning process that has involved hundreds of interested citizens. Seven Regional Strategic Planning Partnerships and statewide Child and Adolescent Services, Forensic Services, Geriatric Services, Mental Retardation Services, and Substance Abuse Services Special Population Workgroups have examined emerging trends; assessed services system strengths, opportunities, challenges, and critical issues; explored opportunities for restructuring the current system; and developed recommendations for the ISP. Appendix A provides a compilation of services system strengths and opportunities, challenges, and emerging trends developed by these groups and recommendations of each Regional Strategic Planning Partnership and Special Population Workgroup.

Using a uniform structure and cross-agency taxonomy of state programs and activities provided by the Department of Planning and Budget, the Department's ASP is intended to align the Department's vision, goals, services, objectives, and resource plans with the guiding principles, long-term vision, and statewide objectives established by the Council for Virginia's Future. The Council was established by §2.2-2684 of the *Code of Virginia* to advise the Governor and the General Assembly on the implementation of the Roadmap for Virginia's Future process.

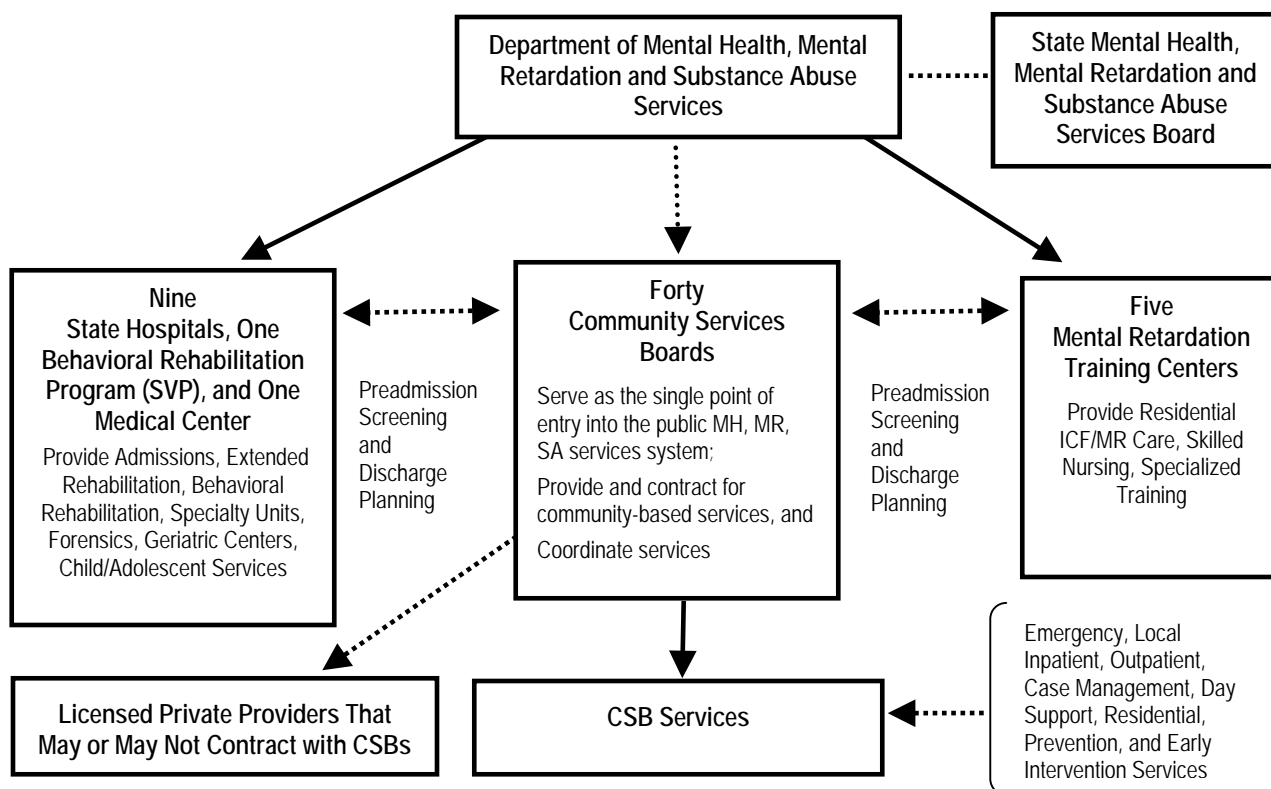
The draft 2006-2012 Comprehensive State Plan was distributed for public review and comment on October 26, 2005. The draft plan also was placed on the Department's website. On November 17, 2005, the State Mental Health, Mental Retardation, and Substance Abuse Services Board and Department conducted a statewide videoconference public hearing to receive public input on the draft Plan. This videoconference public hearing was broadcast to seven sites: Blacksburg, Chesapeake, Chesterfield, Falls Church, Harrisonburg, Lynchburg, and Marion. Across the Commonwealth, 40 individuals attended and 17 individuals spoke at the public hearing. In addition to comments received at the public hearing, the Department received 16 comments by mail, fax, or e-mail. At its December 7, 2005 meeting, the State Board reviewed public hearing testimony and other written comments on the draft Plan, considered changes proposed by the Department in response to this public comment, and supported the revised Plan.

II. SERVICES SYSTEM OVERVIEW

Services System Structure and Statutory Authority

Virginia's public services system includes the Department, the State Mental Health, Mental Retardation, and Substance Abuse Services Board (the State Board), 16 state operated hospitals and training centers operated by the Department, and 39 community services boards and one behavioral health authority (referred to as CSBs) that provide services directly or through contracts with private providers. Maps of CSB service areas and the locations of state facilities are contained in Appendix B.

The following diagram outlines the relationships between these services system components. Solid lines depict a direct operational relationship between the involved entities (e.g., the Department operates state facilities). Broken lines depict non-operational relationships (e.g., policy direction, contracting, or coordination).



Title 37.2 of the *Code of Virginia* establishes the Department as the state authority for mental health, mental retardation, and substance abuse services. By statute, the State Board offers policy direction for Virginia's services system.

The mission of the Department's central office is to provide leadership and service to improve Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, mental retardation, or substance use disorders (alcohol and other drug dependence or abuse). The central office seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals.

Responsibilities of the Department include:

Providing leadership that promotes strategic partnerships among and between CSBs, state facilities, and the Central Office and effective relationships with other agencies and providers;

Providing direct care, treatment, and habilitation services in state hospitals (civil and forensic) and training centers;

Supporting the provision of accessible and effective community mental health, mental retardation, and substance abuse treatment and prevention services through the network of CSBs;

Assuring that public and private mental health, mental retardation, and substance abuse services providers adhere to licensing standards; and

Protecting the human rights of individuals receiving mental health, mental retardation, or substance abuse services.

Characteristics of Community Services Boards and Trends

Community services boards function as the single point of entry into publicly-funded mental health, mental retardation, and substance abuse services, including preadmission screening to access needed state facility services, case management and coordination of services, and discharge planning for individuals leaving state facilities. CSBs provide community mental health, mental retardation, and substance abuse services, directly and through contracts with other providers. They are the primary locus of programmatic and financial accountability for publicly funded mental health, mental retardation, and substance abuse services. CSBs are community educators, organizers, and planners and serve as advocates for individuals receiving CSB services and persons in need of services. They serve as advisors to the local governments that established them.

CSBs exhibit tremendous variety in almost all aspects of their composition, organizational structures, and array of services. Section 37.2-100 of the *Code of Virginia* defines three types of CSBs: operating CSBs, administrative policy CSBs, and policy-advisory CSBs with local government departments (LGDs). Chapter 6 in Title 37.2 of the *Code of Virginia* authorizes certain localities to establish behavioral health authorities (BHAs). In this Plan, CSB or community services board means CSB, BHA, and local government department with a policy-advisory board.

Combined Classification of Community Services Boards

CSB Classification	Functions as LGD	Cities and/or Counties Served		Total CSBs
		One	Two or More	
Administrative Policy CSBs ¹	7	7	3	10
LGD with Policy-Advisory CSB	1	1	0	1
Operating CSB ²	0	2	26	28
Behavioral Health Authority ²	0	1	0	1
TOTAL CSBs	8	11	29	40

¹ Seven of these CSBs are city or county departments; even though 3 CSBs are not, all use local government employees to staff the CSB and deliver services.

² Employees in these 28 CSBs and in the BHA are board, rather than local government, positions.

CSBs are not part of the Department. The Department's relationships with all CSBs are based on the community services performance contract. The Department funds, monitors, licenses, regulates, and provides consultation to CSBs.

CSB Mental Health Services

Eligibility for mental health services provided by CSBs is determined by clinical criteria for each local program. Emergency services are available to anyone in the geographic area served by the CSB, while other services are generally targeted to residents of the CSB service area. In FY 2004, 109,175 individuals received CSB mental health services. This represents an unduplicated count of all individuals receiving any mental health services. Numbers of individuals receiving CSB mental health services by core service follow.

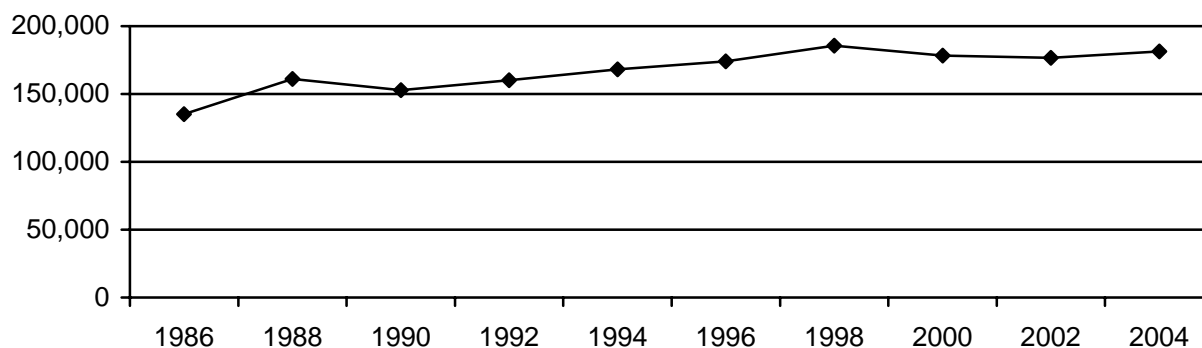
Number of Individuals Receiving CSB Services by MH Core Service in FY 2004

Core Service	# Served	Core Service	# Served
Emergency Services	42,786	Supported Employment - Group Models	62
Local Inpatient Services	1,830	Alternative Day Support Arrangements	198
Outpatient Services	72,823	TOTAL Day Support Services	10,077
Intensive In-Home	2,408	Highly Intensive Residential	294
Case Management	43,537	Intensive Residential	182
Assertive Community Treatment	486	Supervised Residential	1,282
TOTAL Outpatient & Case Management	119,254	Supportive Residential	4,874
Day Treatment/Partial Hospitalization	439	Family Support	122
Therapeutic Day Treatment - C&A	1,381	TOTAL Residential Services	6,754
Rehabilitation Services	5,634	Early Intervention Services	695
Sheltered Employment Services	51	TOTAL Individuals Served	181,396
Supported/Transitional Employment	2,312	TOTAL Unduplicated Individuals	109,175

Source: 2005 Overview of Community Services Delivery in Virginia, June 1, 2005, Department.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2004, the numbers of individuals receiving various CSB mental health services grew from 135,182 to 181,396, an increase of 34 percent. Trends in the numbers of individuals receiving mental health services from CSBs are displayed on the following graph.

Trends in Numbers of Individuals Receiving MH Services From CSBs FY 1986 - FY 2004



These numbers are duplicated counts of individuals receiving services because they are derived from fourth quarter CSB reports that display numbers of people receiving services by core service categories.

CSB Mental Retardation Services

In FY 2004, 23,925 individuals received CSB mental retardation services. This represents an unduplicated count of all individuals receiving any mental retardation services. Numbers of individuals receiving CSB mental retardation services by core service follow.

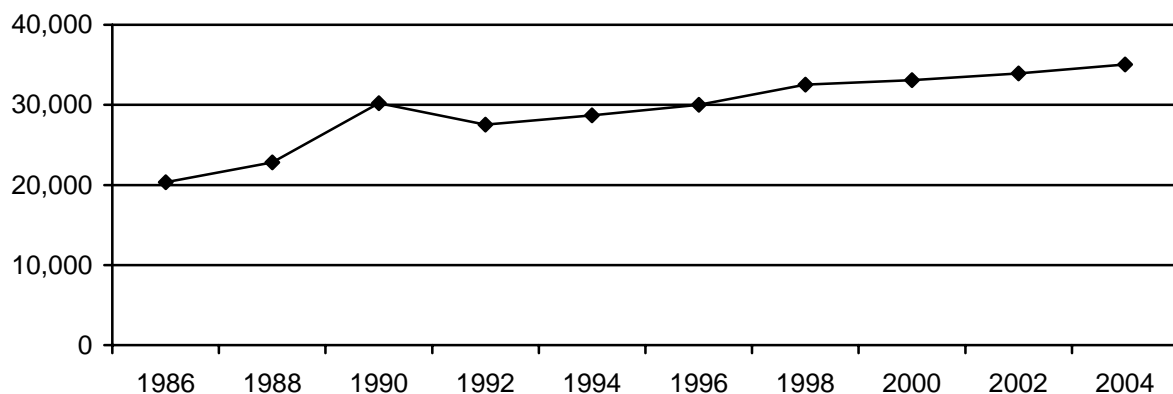
Number of Individuals Receiving CSB Services by MR Core Service in FY 2004

Core Service	# Served	Core Service	# Served
Intensive In-Home	141	Highly Intensive Residential	84
Case Management	15,147	Intensive Residential	741
Consumer Monitoring	1,073	Supervised Residential	624
TOTAL Outpatient & Case Management	16,361	Supportive Residential	1,314
Rehabilitation Services	2,369	Family Support	2,166
Sheltered Employment Services	1,127	TOTAL Residential Services	4,929
Supported/Transitional Employment	1,184	Early Intervention Services	7,778
Supported Employment - Group Models	721	TOTAL Individuals Served	35,038
Alternative Day Support Arrangements	569	TOTAL Unduplicated Individuals	23,925
TOTAL Day Support Services	5,970		

Source: 2005 Overview of Community Services Delivery in Virginia, June 1, 2005, Department.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2004, the numbers of individuals receiving various CSB MR services grew from 20,329 to 35,038, or by 72 percent. Trends in the numbers of individuals receiving mental retardation services from CSBs are displayed on the following graph.

Trends in Numbers of Individuals Receiving MR Services From CSBs FY 1986 - FY 2004



These numbers are duplicated counts of individuals receiving mental retardation services because they are derived from fourth quarter CSB reports that display numbers of people receiving services by core service categories.

CSB Substance Abuse Services

In FY 2004, 53,854 individuals received services for substance use disorders from CSBs. Numbers of individuals receiving CSB substance abuse services by core service follow.

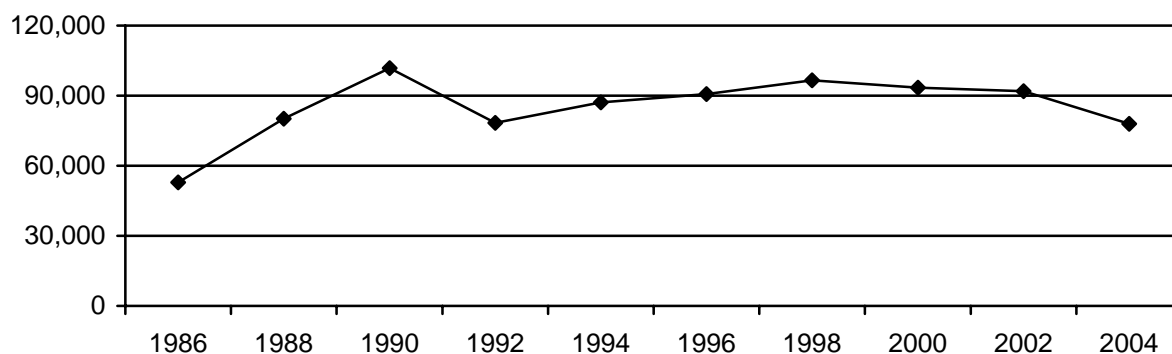
Number of Individuals Receiving CSB SA Services by Service in FY 2004

Core Service	# Served	Core Service	# Served
Emergency Services	6,564	Alternative Day Support Arrangements	33
Local Inpatient	1,235	TOTAL Day Support Services	1,820
Community Hospital-Based Detox	932	Highly Intensive Residential	4,233
TOTAL Local Inpatient Services	2,167	Jail-Based Habilitation	3,916
Outpatient Services	39,423	Intensive Residential	1,780
Motivational Treatment	492	Supervised Residential	276
Case Management	12,325	Supportive Residential	927
Methadone Detoxification	238	Family Support	14
Opioid Replacement Therapy	1,949	TOTAL Residential Services	11,146
TOTAL Outpatient & Case Management	54,427	Early Intervention Services	1,884
Day Treatment/Partial Hospitalization	1,781	TOTAL Individuals Served	78,008
Supported/Transitional Employment	6	TOTAL Unduplicated Individuals	53,854

Source: 2005 Overview of Community Services Delivery in Virginia, June 1, 2005, Department.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2004, the numbers of individuals receiving various CSB substance abuse services grew from 52,942 to 78,008, an increase of 47 percent. Trends in the numbers of individuals receiving substance abuse services from CSBs are displayed on the following graph.

**Trends in Numbers of Individuals Receiving SA Services From CSBs
FY 1986 - FY 2004**



These numbers are duplicated counts of individuals receiving services because they are derived from fourth quarter CSB reports that display numbers of people receiving services by core service categories.

In summary, 186,954 individuals received CSB mental health, mental retardation, and substance abuse services in FY 2004. This represents the unduplicated numbers of individuals

served in each program area. With the implementation in FY 2004 of the Community Consumer Submission (software that extracts data on individuals receiving services from CSB information systems and transmits encrypted data to the Department), a totally unduplicated count of individuals receiving services from CSBs across all program areas, rather than in each program area is available for the first time. In FY 2004, 167,096 individuals received services from CSBs. Appendix C contains detailed information on CSB service utilization trends, levels of functioning or disability for individuals served by CSBs in FY 2004, and condensed core services definitions.

Characteristics of State Hospitals and Training Centers and Trends

State Hospitals

State hospitals provide highly structured intensive inpatient services, including a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. Specialized programs are provided for geriatric, child and adolescent, and forensic individuals. The Joint Commission for Accreditation of Healthcare Organizations (JACHO) has accredited all state hospitals. Child and adolescent services provided by the Southwestern Virginia Mental Health Institute and the Commonwealth Center for Children and Adolescents (CCCA) are licensed under the CORE regulations for residential children's services. The Hiram Davis Medical Center (HDMC) provides medical and skilled nursing services to individuals receiving state facility services. A new behavioral rehabilitation facility, the Virginia Center for Rehabilitative Services (VCBR) opened in October 2003. This facility provides individualized rehabilitation services in a secure facility to individuals who are civilly committed as sexually violent predators.

Operating (staffed) bed capacities for the state hospitals follow.

Mental Health Facility Operating Capacities – June 30, 2005

MH Facility	# Beds	MH Facility	# Beds	MH Facility	# Beds
Catawba Hospital	120	Eastern State Hospital	481	Southern VA MHI	72
Central State Hospital	277	Northern VA. MHI	127	Southwestern VA MHI	172
CCCA	48	Piedmont Geriatric	135	Western State Hospital	254
TOTAL OPERATING CAPACITY (BEDS)					1,686

Note: HDMC, with an operating capacity of 74 beds, and VCBR, with an operating capacity of 36 beds, are not included in this table.

The average daily census by facility follows.

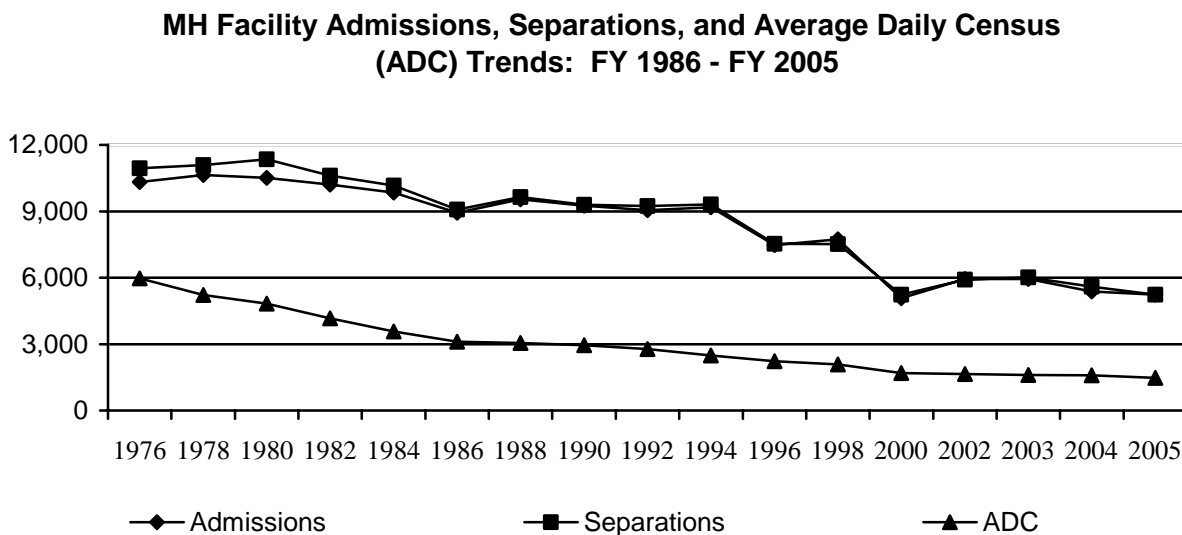
Mental Health Facility Average Daily Census (ADC) – FY 2005

MH Facility	ADC	MH Facility	ADC	MH Facility	ADC
Catawba Hospital	100	Eastern State Hospital	409	Southern VA MHI	69
Central State Hospital	244	Northern VA. MHI	123	Southwestern VA MHI	143
CCCA	29	Piedmont Geriatric	118	Western State Hospital	243
TOTAL STATE MH FACILITY AVERAGE DAILY CENSUS					1,478

Note: HDMC, with an ADC of 67, and VCBR, with an ADC of 12, are not included in this table.

Between FY 1976 and FY 1996, the average daily census at state hospitals, excluding the Hiram Davis Medical Center, declined by 3,745, or 63 percent (from 5,967 to 2,222). Between FY 1996 and FY 2005, the average daily census declined by 33 percent (from 2,222 to 1,478). Between FY 1996 and FY 2005, excluding the Hiram Davis Medical Center and the Virginia Center for Behavioral Rehabilitation, admissions declined by 30 percent (from 7,468 to 5,232) and separations (discharges) declined by 30 percent (from 7,529 to 5,236).

Admission, separation, and average daily census trends (FY 1976 - FY 2005) for state hospitals, excluding the Hiram Davis Medical Center and the Virginia Center for Behavioral Rehabilitation, follow.



Note: Includes the Virginia Treatment Center for Children through FY 1991, when it transferred to the Medical College of Virginia.

Training Centers

Training centers, operated by the Department, provide highly structured habilitation services, including residential care and training in areas such as language, self-care, independent living, socialization, academic skills, and motor development for individuals with mental retardation. All training centers are certified by the U.S. Centers for Medicare and Medicaid (CMS) as meeting Medicaid standards of quality. Each training center operates as an Intermediate Care Facility for the Mentally Retarded (ICF/MR). In addition, Central Virginia Training Center provides skilled nursing services.

Operating (staffed) bed capacities for each training center follow.

Training Center Operating Capacities—June 30, 2005

Training Center	# Beds	Training Center	# Beds
Central Virginia Training Center	611	Southside Virginia Training Center	395
Northern Virginia Training Center	200	Southwestern Virginia Training Center	223
Southeastern Virginia Training Center	200	TOTAL OPERATING CAPACITY (BEDS)	1,629

The average daily census by training center follows.

Training Center Average Daily Census (ADC)–FY 2005

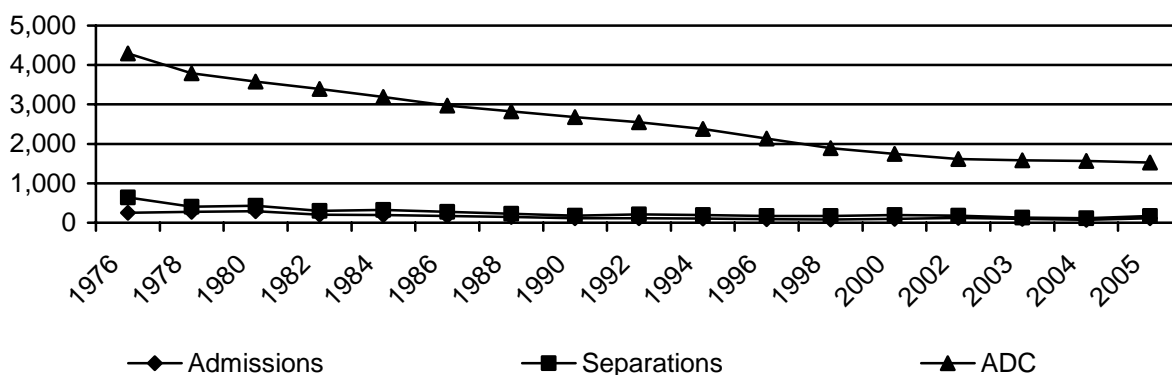
Training Center	ADC	Training Center	ADC
Central Virginia Training Center	564	Southside Virginia Training Center	371
Northern Virginia Training Center	182	Southwestern Virginia Training Center	214
Southeastern Virginia Training Center	193	TOTAL AVERAGE DAILY CENSUS	1,524

Between FY 1976 and FY 1996, the average daily census at training centers declined by 2,161, or 51 percent (from 4,293 to 2,132). Between FY 1996 and FY 2005, the average daily census declined by 29 percent (from 2,132 to 1,524). Between FY 1996 and FY 2005, training center admissions increased by 31 percent (from 87 to 114). Between FY 1996 and FY 2005, training center separations (discharges) decreased by 22 percent (from 223 to 174).

Admission to a training center is governed by §37.2-806 of the *Code of Virginia* (regular admission through the judicial certification process) and by §37.2-2.807 and regulations promulgated under that statute (emergency and respite admission for up to 21 days). Applicants for admission must have a diagnosis of mental retardation and have deficits in at least two of seven areas of adaptive functioning. Applications for admission are made through the CSB in the locality where the applicant resides. Applicants who meet the criteria for admission to an ICF/MR must be offered the choice of receiving services in an ICF/MR or through the Medicaid Mental Retardation Home and Community-Based Waiver.

Admission, separation, and average daily census trends (FY 1976 – FY 2005) for training centers follow.

Training Center Admissions, Separations, and Average Daily Census (ADC) Trends: FY 1986 - FY 2005

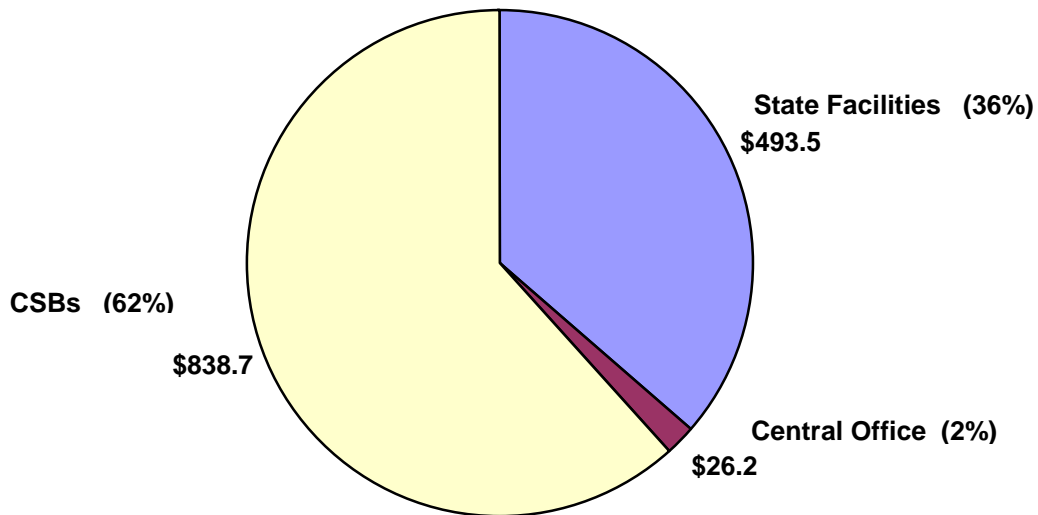


Appendix D contains detailed state facility utilization information, including the numbers served, average daily census, admissions, separations, and utilization, by CSB.

Services System Funding and Trends

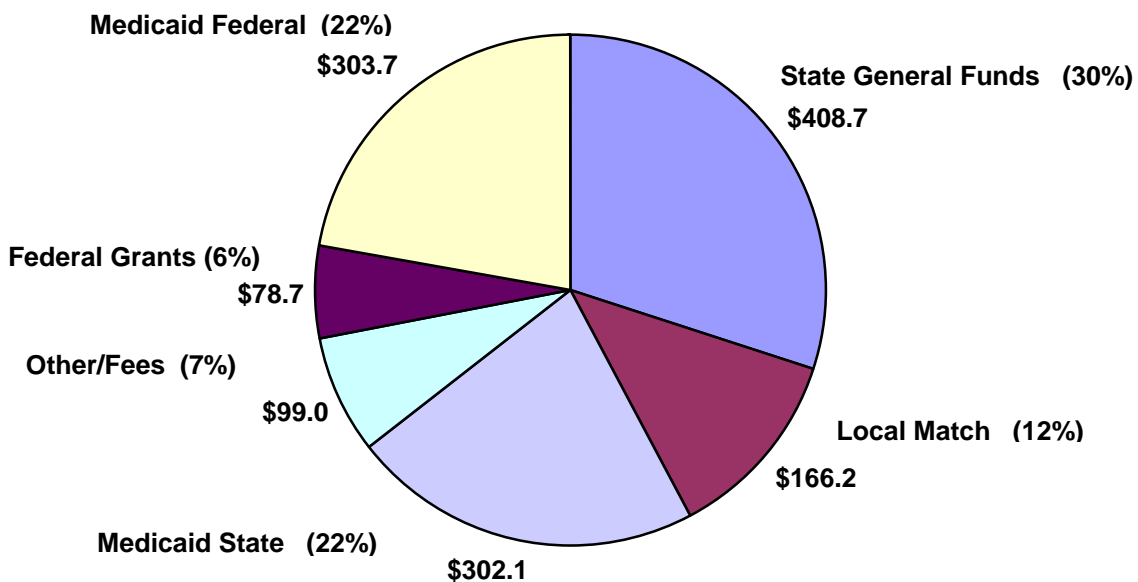
Charts depicting the services system's total resources for **FY 2004** from **all sources** (rounded and in millions), including the Department's final adjusted appropriation, local matching funds, all fees, and Medicaid Mental Retardation Home and Community-Based Waiver (MR Waiver) payments to private vendors, follow.

FY 2004 Total Services System Funding
\$1,358.4 Million



Dollars Above Are in Millions

FY 2004 Total Services System Funding
\$1,358.4 Million

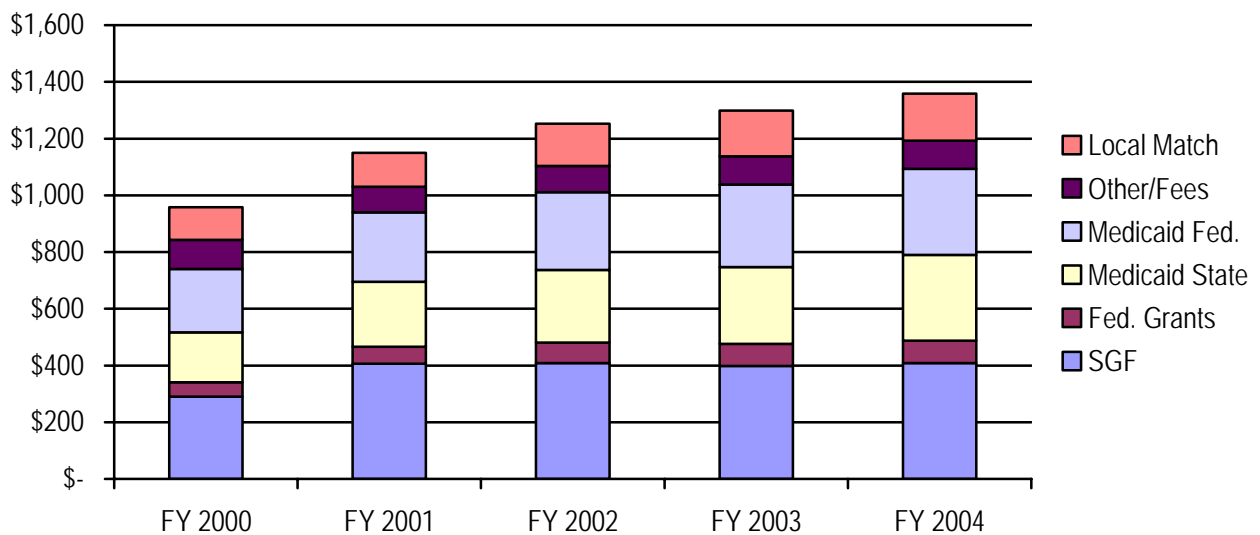


Dollars Above Are in Millions

Funding Trends

Between FY 2000 and FY 2004, total services system funding grew by 23 percent from \$1,106.3 million to \$ 1,358.4 million. The following table depicts funding by source (in millions) for this time period.

	FY 2000	FY2001	FY 2002	FY 2003	FY 2004
State General Funds	399.9	406.5	408.2	398.2	408.7
Federal Grants	56.2	59.8	72.2	78.3	78.7
Medicaid - State	209.0	228.4	256.9	270.7	302.1
Medicaid - Federal	223.2	245.5	273.3	290.5	303.7
Other/Fees	102.0	90.6	92.8	99.2	99.0
Local Match	115.9	118.9	149.3	162.1	166.2
Total	\$1,106.3	\$1,149.7	\$1,252.7	\$1,299.0	\$1,358.4



Dollars above are in millions

III. DESCRIPTIONS OF POPULATIONS SERVED AND PREVALENCE ESTIMATES

Individuals Who Have a Serious Mental Illness or Serious Emotional Disturbance

A mental disorder is broadly defined in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (the *DSM IV*) as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment of one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental disorders are common. The annual prevalence of these disorders is nearly 20 percent, and the lifetime prevalence of all mental disorders in the general population is 20-25 percent. Only a portion of individuals with diagnosable disorders will need services at any given time and an even smaller portion will require or seek services from the public sector.

There have been many significant advances in the treatment of mental illness, to the extent that today, there are many effective treatments for most mental disorders. In addition to emergency services that are available to any individual in crisis, Virginia's public services system provides services to adults who have serious mental illnesses and children who have or are at risk of having serious emotional disturbance.

Serious Mental Illness means a severe and persistent mental or emotional disorder that seriously impairs the functioning of adults, 18 years of age or older, in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals with serious mental illness who also have been diagnosed as having a substance use disorder or mental retardation are included in this definition. Serious mental illness is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

- **Diagnosis:** an individual must have a major mental disorder diagnosed under the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV, Fourth Edition). These disorders are: schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability.
- **Level of Disability:** There must be evidence of severe and recurrent disability resulting from mental illness that must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis.
 - a. Is unemployed or employed in a sheltered setting or a supportive work situation, has markedly limited or reduced employment skills, or has a poor employment history.
 - b. Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
 - c. Has difficulty establishing or maintaining a personal social support system.
 - d. Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
 - e. Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.
- **Duration of Illness:** The individual is expected to require services of an extended duration, or his treatment history meets at least one of the following criteria.
 - a. The individual has undergone psychiatric treatment more intensive than outpatient care, such as crisis response services, alternative home care, partial hospitalization, or inpatient hospitalization, more than once in his or her lifetime.
 - b. The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

Substance use disorders frequently occur in conjunction with serious mental illness.

Serious Emotional Disturbance means a serious mental health problem that affects a child, age birth through 17, and can be diagnosed under the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* or meets specific functional criteria.

- Problems in personality development and social functioning that have been exhibited over at least one year's time,
- Problems that are significantly disabling based on social functioning of most children of the child's age,
- Problems that have become more disabling over time, and
- Service needs that require significant intervention by more than one agency.

Substance use disorders frequently occur in conjunction with serious emotional disturbance.

Children "At-Risk" of Serious Emotional Disturbance means a condition experienced by a child, age birth through 7, which meets at least one of the following criteria:

- The child exhibits behavior or maturity is significantly different from most children of the child's age, and is not due to developmental disability or mental retardation, or
- Parents or persons responsible for the child's care have predisposing factors themselves, such as inadequate parenting skills, substance use disorder, mental illness, or other emotional difficulties, that could result in the child developing serious emotional or behavior problems, or
- The child has experienced physical or psychological stressors, such as living in poverty, parental neglect, or physical or emotional abuse, which put him at risk for serious emotional or behavior problems.

Individuals Who Have Mental Retardation

Mental retardation, as defined in the *Code of Virginia*, means a disability means a disability originating before the age of 18 years, characterized concurrently by (i) significantly subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

With each individual, limitations often co-exist with strengths. With appropriate personalized supports over a sustained period, the life functioning of the individual with mental retardation generally will improve; however, mental retardation is a life-long disability.

Individuals Who Have a Substance-Use Disorder

Substance use disorders (SUDs) are types of mental disorders that are "related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, and to toxin exposure" (DSM IV, Fourth Edition). There are two levels of substance use disorders: substance addiction (dependence) or substance abuse.

- Substance addiction (dependence), as defined by ICD-9, means uncontrollable substance-seeking behavior involving compulsive use of high doses of one or more substances resulting in substantial impairment of functioning and health. Tolerance and withdrawal are characteristics associated with dependence. Dependence is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following occurring at any time in the same 12-month period.
 1. Needing markedly increased amounts of the substance to achieve intoxication or a desired effect or having a markedly diminished effect with continued use of the same
 2. Having the characteristic withdrawal syndrome for the substance or the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;
 3. Taking larger amounts of the substance or over a longer period than was intended;

4. Having a persistent desire or unsuccessful efforts to cut down or control substance use;
 5. Spending a great deal of time on activities necessary to obtain the substance, use the substance, or recover from its effects;
 6. Giving up or reducing important social, occupational, or recreational activities because of substance use; and
 7. Continuing substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Substance abuse as defined by ICD-9, means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. It leads to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period:
 1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household);
 2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
 3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); and
 4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

Prevalence Estimates

When planning for Virginia's future public mental health, mental retardation, and substance abuse services system, it is important to have a sense of how many individuals might seek care from the services system. This section uses national epidemiological studies as the basis for extrapolating Virginia prevalence rates for adults with serious mental illnesses, children and adolescents with serious emotional disturbances, individuals with mental retardation, and individuals with substance use disorders. Prevalence is the total number of cases within a year. This differs from incidence, which is the number of new cases within a year. Total population prevalence estimates are based on the 2003 Final Estimated Population data from the Weldon Cooper Center for Public Service at the University of Virginia.

Estimated Prevalence for Adults with Serious Mental Illnesses: An estimate of the number of adults between the ages of 18 and 69 years of age with serious mental illnesses was developed using the methodology published by the U.S. Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Federal Register, Volume 64, No. 121, Thursday, June 24, 1999. This methodology, which estimates that 5.4 percent of the state's resident population has a serious mental illness, was applied to the 2003 Final Estimated Population data to estimate that 298,246 adults in Virginia have a serious mental illness.

Estimated Prevalence for Children and Adolescents With Serious Emotional Disturbance: An estimate of the number of children and adolescents between the ages of 9 and 17 with serious emotional disturbances was developed using the methodology published by the U.S. Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Federal Register, Volume 63, No. 137, Friday, July 17, 1998. These prevalence rates were applied to the 2003 Final Estimated Population data to estimate that between 92,346 and 110,815 children and adolescents in Virginia have a serious emotional disturbance (level of functioning score of 60). Between 55,407 and 73,877 have serious emotional disturbance with extreme impairment (level of functioning score of 50).

Prevalence of Mental Retardation: There is no generally accepted nationally recognized mental retardation prevalence rate for the general population, in large part because of definitional issues and differences in the types of data used to produce the prevalence estimates. In *Closing the Gap, A National Blueprint to Improve the Health of Persons with Mental Retardation: Report of the Surgeon General's Conference on Health Disparities and Mental Retardation, 2002*, Dr. Bonnie Kerker's Overview Presentation on the Prevalence of Mental Retardation cites data showing that approximately 0.3 to 3.1 percent of the general population and about 1.1 percent of all children have mental retardation. Most of these individuals are classified as having mild mental retardation.

A 1993 study of mental retardation prevalence rates, *State Specific Rates of Mental Retardation – United States, 1993*. MMWR Weekly (Jan. 26, 1996), 45, #3: 61-65, used data from the U.S. Department of Education for children with mental retardation who were enrolled in special education programs and data from the Social Security Administration (SSA) to estimate an overall mental retardation prevalence rate of 1 percent, or 7.2 cases per 1,000 persons. This rate was applied to Virginia's population, using 2003 Final Estimated Population data to estimate that 67,477 Virginians age 6 and over have mental retardation.

This estimate is conservative because Department of Education data does not include individuals who never enrolled in or who dropped out of school and SSA eligibility, because it is based on both personal income and the presence of a disability, may exclude adults with mental retardation who do not meet SSA income eligibility requirements.

The prevalence rate nationally for children born with birth defects is between 3 and 5 percent of children born annually. Using national and Virginia studies of children with specific diagnoses selected by Virginia, estimates of children with delay influenced by Virginia poverty rates, prevalence of low birth weight children, children identified on hearing registry; children assessed and requiring services in one year, and rates of states with comparable eligibility, the Department estimates that 3 percent of Virginia's infants and toddlers are potentially eligible for Part C services. These studies include: *Estimating Service Needs: An Epidemiological Approach* (OSEP Technical Assistance Document, 2000), *Virginia Congenital Anomalies Reporting and Education System, Birth Defects Surveillance Data 1989-1998* (Virginia Department of Health, 2003), *Analysis of Part C Individual Child Data for 1998-2002, Final Report* (Old Dominion University, 2003), *State and Jurisdictional Eligibility Definitions for Infants and Toddlers with Disabilities Under IDEA* (NECTAC Notes, Issue 11, 2005), *A First Look at the Characteristics of Children and Families Entering Early Intervention, September 27, 2002*, and *National Early Intervention Longitudinal Study* (U.S. Department of Education Data Analysis System, 2004). The 3 percent estimated rate was applied to Virginia's population, using 2003 Final Estimated Population data to estimate that 18,116 Virginia infants and toddlers need early intervention services.

Prevalence of Substance Use Disorders: Prevalence estimates of substance abuse and dependence in the past year for individuals who are age 12 and over were obtained from the 2002 and 2003 National Household Surveys on Drug Use and Health (NSDUH). Using 2003 Final Estimated Population data, estimated prevalence of adults and adolescents reporting past year dependence or abuse of alcohol or other drugs follows:

- Dependence on or abuse of any illicit drug – 3.03 percent or 185,869 Virginians, of which 1.99 percent or 122,072 met the criterion for dependence.
- Dependence on or abuse of alcohol – 7.33 percent or 449,644 Virginians, of which 3.47 percent or 213,473 met the criterion for dependence.

State data from these surveys should not be compared with data from previous years due to significant methodological changes implemented in the 2003 survey.

Appendix E contains prevalence estimates for serious mental illness, serious emotional disturbance, mental retardation, and drug and alcohol dependence by CSB.

IV. CURRENT AND FUTURE SERVICE NEEDS

CSB Waiting Lists

The following table displays the number of individuals who were on CSB waiting lists for community mental health, mental retardation, or substance abuse services during the first three months of 2005.

Numbers of Individuals on CSB Waiting Lists for Mental Health, Mental Retardation, or Substance Abuse Services: January Through April 2005

Populations of CSB Waiting Lists	Numbers Who ARE Receiving Some CSB Services	Numbers Who Are NOT Receiving Any CSB Services	Total Numbers on CSB Waiting Lists
CSB Mental Health Waiting List Count			
Adults with a Serious Mental Illnesses	3,554	811	4,365
Children and Adolescents With or At Risk of Serious Emotional Disturbance	1,377	625	2,002
Total MH	4,931	1,436	6,367
CSB Mental Retardation Waiting List Count			
Individuals on CSB Waiting Lists for MR Waiver and Non-Waiver Services	4,236	938	5,174
CSB Substance Abuse Waiting List Count			
Adults with Substance Use Disorders	2,011	981	2,992
Adolescents with Substance Use Disorders	255	142	397
Total SA	2,266	1,123	3,389
Total CSB Mental Health, Mental Retardation, or Substance Abuse Services Waiting List Count			
Grand Total on All CSB Waiting Lists	11,433	3,497	14,930

During the time period during which the CSB mental retardation waiting lists were completed, 968 persons on these lists also were on the MR Home and Community-Based Waiver urgent waiting list, 1,200 were on the waiver non-urgent list, and 739 were on CSB waiver planning lists.

To be included on the waiting list for CSB services, an individual had to have sought the service and been assessed by the CSB as needing that service. CSB staff also reviewed their active cases to identify individuals on their active caseloads who were not receiving all of the amounts or types of services that they needed. This point-in-time methodology for documenting unmet service demand is conservative because it does not identify the number of persons who needed services over the course of a year. Appendix F depicts numbers of individuals on waiting lists for mental health, mental retardation, and substance abuse services by CSB.

Diagnostic information and special conditions and risk factors of individuals on waiting lists for CSB mental health, mental retardation or substance abuse services follow.

**Individuals on CSB Mental Health Services Waiting Lists Diagnostic Information
January – April 2005**

Special Condition or Risk Factor	Adult	C&A
Meets the Criteria as Having a Serious Mental Illness (SMI)	2,792	
Meets the Criteria as Having a Serious Emotional Disturbance (SED)		1,302
Any Other MI Diagnosis	625	
Any Other ED or MI Diagnosis		365
Co-occurring MI/SUD	938	65
Co-occurring MI/MR	161	52
Co-occurring MI/MR/SUD	17	1
Developmental Disability Other Than Mental Retardation	37	58
Not Known at This Time	370	374

**Numbers of Individuals on CSB Mental Health Services Waiting Lists with Special
Conditions or Risk Factors: January – April 2005**

Special Condition or Risk Factor	Adult	C&A
Deafness or Hearing Loss	85	9
Blindness or Visual Impairment	87	16
Non-ambulatory or Major Difficulty in Ambulation	141	5
Unable to Communicate with Verbal Speech	33	14
Traumatic Brain Injury	76	12
Dementia	64	
High or Extensive Behavioral Challenges	622	918
High or Extensive Physical or Personal Care Needs	349	66
Concurrent Major Medical Condition or Chronic Health Problem	1,240	86
Limited English Proficiency (National Origin)	74	14
At Risk of Being Homeless or Out of Home Placement	833	313
Current Residence Is Not Satisfactory or Appropriate to Individual's Needs	558	93
Current Residence Is Satisfactory But Supports Provided are Inadequate	566	238
Currently Unemployed or No Day Support Options	1,932	
Receiving Special Education		618
Currently Truant, Expelled, Suspended, or School Drop Out		173
Social Supports Are Limited or Lacking	2,019	518
Aging Care Giver	208	98

Special Condition or Risk Factor	Adult	C&A
Care Giver Illness or Disability	99	
Care Giver Is Unable or Unwilling to Provide Support		150
No Guardian or Legally Authorized Representative	250	2
Family Has Petitioned to be Relieved of Custody to Receive Services		11
Aging Out of CSA or Foster Care Financing for Residential Services		32
Social Services/Juvenile Justice System Involvement		397
In Jail, Correctional Facility, or Criminal Justice Involvement	222	
Lacks Transportation	1,162	91
No Special Conditions or Risk Factors	365	229
Special Conditions or Risk Factors Not Known at This Time	472	325

**Individuals on CSB Mental Retardation Services Waiting Lists Diagnostic Information
January – April 2005**

Special Condition or Risk Factor	Total
Meets the Criteria as Having Mental Retardation	4,045
Meets the Criteria as Having Cognitive Developmental Delay	453
At Risk for Cognitive Developmental Delay	48
Co-occurring MR/MI	644
Co-occurring MIR/SUD	21
Co-occurring MR/MR/SUD	21
Autism	403
Developmental Disability Other Than Mental Retardation or Autism	377
Not Known at This Time	85

**Numbers of Individuals on CSB Mental Retardation Services Waiting Lists with Special
Conditions or Risk Factors: January – April 2005**

Special Condition or Risk Factor	Individuals
Deafness or Hearing Loss	198
Blindness or Visual Impairment	340
Non-ambulatory or Major Difficulty in Ambulation	623
Unable to Communicate with Verbal Speech	979
Traumatic Brain Injury	63
Dementia	27

Special Condition or Risk Factor	Individuals
High or Extensive Behavioral Challenges	1,089
High or Extensive Physical or Personal Care Needs	936
Concurrent Major Medical Condition or Chronic Health Problem	956
Limited English Proficiency (National Origin)	139
At Risk of Being Homeless	222
Current Residence Is Not Satisfactory or Appropriate to Individual's Needs	183
Current Residence Is Satisfactory But Supports Provided are Inadequate	1,329
Currently Unemployed or No Day Support Options	556
Social Supports Are Limited or Lacking	1,165
Aging Care Giver (Caregiver is 55 or older)	944
Care Giver Illness or Disability	517
Family Has Petitioned to be Relieved of Custody to Receive Services	25
No Guardian or Legally Authorized Representative	441
An Application for Training Center Placement Has Been Initiated	34
Aging Out of CSA or Foster Care Financing for Residential Services	80
Aging Out of Special Education	443
In Jail, Correctional Facility, Juvenile Detention Facility, or Criminal Justice Involvement	38
Lacks Transportation	696
No Special Conditions or Risk Factors	516
Special Conditions or Risk Factors Not Known at This Time	325

**Individuals on CSB Substance Abuse Services Waiting Lists Diagnostic Information
January – April 2005**

Special Condition or Risk Factor	Adult	Adolescents
Meets the Criteria for Substance Dependence	1,310	57
Meets the Criteria for Substance Abuse	1,261	155
Any Other SA Diagnosis	696	67
Co-occurring SUD/MI	913	142
Co-occurring SUD/MR	13	3
Co-occurring SUD/MI/MR	6	1
Developmental Disability Other Than Mental Retardation	12	2
Not Known at This Time	272	76

Numbers of Individuals on CSB Substance Abuse Services Waiting Lists with Special Conditions or Risk Factors: January – April 2005

Special Condition or Risk Factor	Adult	Adolescents
Deafness or Hearing Loss	18	1
Blindness or Visual Impairment	14	1
Non-ambulatory or Major Difficulty in Ambulation	32	0
Unable to Communicate with Verbal Speech	6	0
Traumatic Brain Injury	48	1
Dementia	3	
High or Extensive Behavioral Challenges	307	132
High or Extensive Physical or Personal Care Needs	57	15
Concurrent Major Medical Condition or Chronic Health Problem	458	5
Limited English Proficiency (National Origin)	67	3
At Risk of Being Homeless or Out of Home Placement	503	77
Current Residence Is Not Satisfactory or Appropriate to Individual's Needs	267	31
Current Residence Is Satisfactory But Supports Provided are Inadequate	206	50
Currently Unemployed	1,087	
Currently Truant, Expelled, Suspended, or School Drop Out		124
Social Supports Are Limited or Lacking	1,133	131
Aging Care Giver	21	11
Care Giver Is Unable or Unwilling to Provide Support	8	34
Family Has Petitioned to be Relieved of Custody to Receive Services		1
Aging Out of CSA or Foster Care Financing for Residential Services		5
Currently Pregnant	27	3
Female who Currently Resides with Dependent Children	245	
IV Drug Use	242	2
In Jail, Correctional Facility, or Criminal Justice Involvement	929	
Department of Social Services/Juvenile Justice System Involvement		264
Lacks Transportation	675	53
No Special Conditions or Risk Factors	316	31
Special Conditions or Risk Factors Not Known at This Time	321	24

The following table depicts the length of time individuals have been on CSB mental health, mental retardation, or substance abuse services waiting lists:

Length of Time on CSB Waiting Lists: January – April 2005

	Mental Health		Mental Retardation	Substance Abuse	
	Adult	C & A		Adult	Adolescent
Under 1 Month	116	58	190	50	18
1 to 3 Months	3,186	1,559	1,033	2,127	259
4 to 12 Months	714	305	962	633	99
13 to 24 Months	178	42	735	132	16
25 to 36 Months	76	21	583	29	3
37 to 48 Months	29	7	392	11	2
49 to 60 Months	22	6	400	7	0
61 to 72 Months	18	1	168	2	0
73+ Months	26	3	711	1	0
Not Reported	7	0	42	0	0

Other Indicators of Community-Based Services Needs

In addition to individuals on waiting lists for CSB mental health, mental retardation, or substance abuse services, there are additional disability-specific, community-based service needs that are significant and compelling.

Virginia Department of Education counts made on December 1, 2004, identify 12,795 students with a primary disability (as defined by special education law) of emotional disturbance and 13,269 students with mental retardation who are receiving special education services. As these students age out of special education services, many will require community-based treatment or habilitation services to maintain the skills they learned in special education.

While the number of Medicaid MR Waiver recipients has increased by 860 in the last two years, the waiting list for community-based MR services and supports is anticipated to grow by approximately 500 new individuals.

Nearly 75 percent of all youth in detention centers have at least one diagnosable mental disorder, yet only five CSBs receive funding to provide joint services with juvenile detention centers.

CSBs serve a large number of infants and toddlers in programs funded through the Part C program; the number of infants and toddlers in need of these services is expected to grow over the biennium as a result of population growth and better outreach and case finding.

The 2003 National Survey on Drug Use and Health estimates that there are 98,000 Virginians needing, but not receiving substance abuse services. Patterns of drug use reflect an increased prevalence of prescription drug and methamphetamine abuse and dependence.

V. CRITICAL ISSUES AND STRATEGIC RESPONSES

A. Transforming Virginia's System of Care

Integrated Strategic Plan for Virginia's Services System

The Department's Integrated Strategic Plan (ISP), *Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation, and Substance Abuse Services System*, (2005) outlines a framework for transforming Virginia's publicly funded mental health, mental retardation, and substance abuse services system to:

- Fully implement self-determination, empowerment, recovery, resilience, and person-centered core values at all levels of the system through policies and practices that reflect the unique circumstances of individuals with one or more of the following: mental illnesses, mental retardation, or substance abuse disorders.
- Incorporate the principles of inclusion, participation, and partnerships into daily operations at all levels.
- Expand services and supports options needed to support individual and family choice, community integration, and independent living.
- Provide sufficient capacity to meet growing individual needs so that individuals with mental illnesses, mental retardation, or substance use disorders, wherever they live in Virginia:
 - Receive the levels of services and supports they need,
 - When and where they need them,
 - In appropriate amounts, and
 - For appropriate durations.
- Promote the health of individuals receiving services, families, and communities.
- Increase opportunities for collaboration among state and community agencies.
- Align administrative, funding, and organizational processes to make it easier for individuals and families to obtain the services and supports they need.
- Monitor performance and measure outcomes to demonstrate that services and supports are appropriate and effective, promote services system improvement, and consistently report on the transformation process.
- Provide stewardship and wise use of system resources, including funding, human resources, and capital infrastructure, to assure that services and supports are delivered in a manner that is efficient, cost-effective, and consistent with evidence-based and best practices.

Vision for the Future Services System in Virginia

The Department is committed to implementing the vision "of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of individual participation in all aspects of community life, including work, school, family and other meaningful relationships" (State Board Policy 1036 (SYS) 05-3).

State and local government have a collective responsibility for assuring the provision of a "safety net" of appropriate services and supports in safe and suitable settings for individuals with mental illnesses, mental retardation, or substance use disorders who are in crisis or who have severe or complex conditions, or both, and cannot otherwise access needed services and

supports because of their level of disability, their inability to care for themselves, or their need for a structured or secure environment.

Implementation of this “safety net” would be flexible and would draw on the collaborative efforts of the Department, CSBs, and other healthcare providers who care for individuals who are uninsured, have one or more of the following disorders: serious mental illnesses, mental retardation, or substance use disorders. This “safety net” would adapt according to the needs of each individual and the availability of services and supports that address those needs. For example, “safety net” crisis stabilization services would be provided as close to an individual’s home and natural supports as possible. Such services might include intensive in-home assistance offered by a MR/MI behavioral intervention team to stabilize the crisis, a brief stay in a local or regional crisis intervention program for persons with mental illnesses or co-occurring disorders, or admission to a community hospital for acute psychiatric or detoxification services. However, when these services are not available or appropriate or more specialized or intensive services are needed, the state would continue to assure the provision of such services. State training centers would provide a safety net for individuals with the most medically complex or behaviorally challenging service needs.

The services system would have a wide “front door” for screening and assessing the needs of individuals who seek publicly funded mental health, mental retardation, or substance abuse services or supports. Referrals to this “front door” would come directly to the CSB or through referrals to CSBs from local hospital emergency rooms or other local agencies. All individuals and families seeking services and supports would receive timely and thorough initial screening and state-of-the-art assessments provided by well-qualified and highly trained staff. Assessment results would determine the types, levels, and amounts of needed services and supports depending upon the complexity of the individual’s condition or his level of functioning. Services and supports options would reflect the core values of self-determination, recovery, resilience, and person-centered planning.

Access to and continuation in the most intensive services would be rigorously screened and continuously reviewed to assure services are provided in the most integrated and least intrusive setting appropriate to the acuity and complexity of the individual’s condition or his level of functioning. Referrals to emergency and crisis services would be immediate. Referrals to non-emergency services and supports provided by the CSBs, peer-run organizations, local agencies, or other providers would be within a reasonable period of time based on individual need. Services utilization, including hospitalization, would be managed by the CSBs in collaboration with other providers, as appropriate, for the period suitable to the needs of the individual.

Services and Supports Principles and Practices

Adults and children with mental illnesses, mental retardation, or substance use disorders are members of the community in which they live and should enjoy the same opportunities for quality of life. The overarching goal of the services system is to provide or assist individuals in obtaining services and supports based on informed choice that would enable them to:

- Attain their highest achievable level of health and wellness;
- Live as independently as possible, with children living with their families;
- Engage in meaningful activities, including school attendance or work in jobs that they have chosen; and
- Participate in community, social, recreational, and educational activities.

The design and operation of services and supports would be based upon the following values:

- Services and supports are person-centered. Individuals receiving services and family members have access to information, are involved in service planning, and have decision-making power over the types of services and supports they need and use. The specific needs of each individual are at the center of service planning and care coordination.
- The services system is designed to intervene early to minimize crises through early screening and assessment, appropriate interventions that keep individuals receiving services connected to their families and natural supports, and seamless access to services.
- Services and supports are available and delivered as close as possible to an individual's home community and in the least restrictive setting possible, are culturally and age sensitive and appropriate, and are fully integrated and coordinated with other community services.
- Adults and children requiring services and supports from multiple agencies are provided care that is coordinated across agencies.
- Services and supports are flexible, allow for the greatest amount of individual choice possible, and provide an array of acceptable options to meet a range of individual needs.
- A consistent minimum level of types and amounts of services and supports is available across the system, with timely access to needed services.
- Prevention, early intervention, and family support services are critical components of the services system.
- Services are universally and equally accessible regardless of the individual's payment source.
- Services are of the highest possible quality and are based upon best and promising practices, where such practices exist.
- Services are provided in an efficient and cost-effective manner to enhance service quality and continuity of care and to take advantage of technologies that provide appropriate access to properly protected information.
- Emphasis is placed on continuous quality improvement at the provider and system levels, with performance and outcome measures focused on self-determination, empowerment, recovery, resilience, and community integration.
- Integrated and flexible public funding of mental health, mental retardation, and substance abuse services promotes person-centered and recovery-oriented service and supports.
- Public funding is adequate to meet individual needs and includes cost inflators to sustain capacity and address the total costs of service delivery.
- The services system is committed to state facility and community workforce training, retraining, development, retention, and expansion to needed staffing levels.

Every locality would have the capacity to provide, either locally or through regional arrangements, crisis access and response 24 hours per day and seven days a week. The following crisis access and response services would be available:

- Locally provided emergency services;
- In-home assistance to stabilize a crisis;
- Non-hospital crisis stabilization and detoxification; and
- Acute stabilization in local hospitals.

Following assessment, services and supports choices would be identified for each individual. These choices would be flexible and provided as close to the individual's home and natural supports as possible. Regardless of where an individual lives in the Commonwealth, individuals

and their families would have access to a broad array of services and supports that promote independence and enable individuals to live in their own homes or natural environments wherever possible, and when not possible, with other family members.

Recovery and resilience-oriented and person-centered services, training, and supports provided by and for individuals and families would be developed and expanded, including:

- Peer-run programs,
- Individual and family education and support,
- Family resource centers,
- Individual wellness recovery planning, and
- Peer-to-peer drop-in centers.

At the local level, recovery and resilience-oriented and person-centered services and supports would include the following core array of services provided by CSBs directly or through contracts with other community providers.

- Prevention and early intervention services,
- Infant and toddler intervention,
- Respite care,
- In-home services, including intensive in-home therapy by licensed clinicians,
- Care coordination and case management,
- Medication and medication education services,
- Outpatient treatment provided by specially trained clinicians using best and promising practices,
- Integrated treatment for individuals with co-occurring MI/SUD, MI/MR, and MR/SUD diagnoses,
- Supported employment and vocational training,
- Rehabilitation and day support services,
- Day treatment provided in schools or clinics,
- Supervised and supportive residential services, and
- Intensive community treatment, training, and transitional services.

In addition, a system of care for children and adolescents would be available. This system of care would include cross-agency planning and coordination at the local level with child-serving agencies and the Comprehensive Services Act teams; with family involvement; respite care services; family supports; behavioral health support for schools, court services, health departments, and social services; and early intervention services through local schools, behavioral health, and other health care clinics.

While it is preferable in most instances to provide services and supports in an individual's home community, there may be situations where needed services are beyond the capacity of most localities to provide. These services and supports would be provided at the regional level through specialized teams, regional programs, or utilization of emerging technologies such as teletherapy or teleconsultation. These services and supports may include:

- Regional MR/MI behavioral consultation teams;
- Regional MI/SUD consultation teams;
- Expert consultation teams for nursing homes and assisted living facilities; and
- Specialty clinical services (e.g., extensive assessments for medical and psychiatric needs, child and family therapy, and medical and dental supports).

The following specialty services would be available statewide or at the regional level.

- Intermediate treatment and rehabilitation and intensive treatment for individuals with severe or complex conditions, or both, requiring care in state hospitals;
- Intensive short-term acute inpatient crisis intervention, stabilization, and treatment for children and adolescents with high acuity or high complexity behavioral health conditions, or both;
- Intensive medical (to include skilled nursing), behavioral, or other specialized supervision and therapeutic interventions for individuals with mental retardation;
- Secure forensic and not guilty by reason of insanity (NGRI) services; and
- Behavioral rehabilitation services for sexually violent predators.

To the extent possible, funding should follow the individual and not a specific provider or service. Integrated funding, with cost of living escalators, would reduce the complexity of funding and provide the flexibility needed to create choices among the core array of services and supports that promote self-determination and person-centered planning, empowerment, recovery, and resilience for individuals receiving services.

MR Services and Supports by Level of Care Model

The Department has developed a Mental Retardation Services and Supports by Level of Care Model to expand the range of services and supports options for individuals who meet the level of care criteria established by Medicaid for ICF/MR eligibility. The MR model promotes flexibility, choice, and independence. It includes five levels of services and supports that range from basic community-based non-residential services and family supports to intensive 24-hour center-based services.

Continued investment in community services and supports capacity is a necessary prerequisite for implementation of the MR model. This includes expansion of community MR Waiver slots to prevent increased demand for the most intensive center-based services, increases in MR Waiver rates to assure community capacity, and expansion of community services and supports, including non-MR Waiver services family supports. The MR model also would develop community living options such as small community ICF/MR and MR Waiver group home capacity as alternatives to more intensive services.

The MR model would establish smaller center-based facilities, or intensive support centers, to provide residential care to those individuals who cannot be served in small ICF or MR Waiver homes. These center-based facilities also would provide medical, dental, behavioral, and other services and supports for community residents through Regional Community Support Centers.

Multi-Agency MH Transformation Initiative

The Department is proposing a Mental Health Transformation Initiative to support planning and infrastructure development activities that are intended to result in comprehensive, cross-agency transformation of the state mental health system. This initiative would build upon the work of the Regional Partnerships and Special Population Workgroups. Through this initiative, the Department would work with the agency heads and senior leadership of the Department, the Department of Rehabilitative Services, the Department of Social Services, the Department of Medical Assistance Services, the Department of Corrections, the Department of Juvenile Justice, and the Department of Housing and Community Development; the Chair of the CSA State Executive Council; and the Inspector General for Mental Health, Mental Retardation, and Substance Abuse Services to develop a comprehensive cross-agency mental health plan to transform Virginia's mental health services system by addressing the six goals and 19

recommendations of the President's New Freedom Commission report, *Achieving the Promise*, with action steps and outcome measures. The comprehensive cross-agency mental health plan will be compatible with the Department's Integrated Strategic Plan and its Comprehensive State Plan. Its development process will be a broad, statewide, participatory process that also will include individuals receiving services, family members, advocates, public and private providers, local government representatives, and other interested stakeholders.

Critical Success Factors

Seven critical success factors described below are required to transform the current services system's "crisis-response" orientation to one that provides incentives and rewards for implementing the vision of a recovery and resilience-oriented and person-centered system of services and supports. Successful achievement of these critical success factors will require the support and collective ownership of all system stakeholders.

1. Virginia successfully implements a recovery and resilience-oriented and person-centered system of services and supports.
2. Publicly funded services and supports that meet growing mental health, mental retardation, and substance abuse services needs are available and accessible across Virginia.
3. Funding incentives and practices support and sustain quality care focused on individuals receiving services and supports, promote innovation, and assure efficiency and cost-effectiveness.
4. State facility and community infrastructure and technology efficiently and appropriately meet the needs of individuals receiving services and supports.
5. A competent and well-trained mental health, mental retardation, and substance abuse services system workforce provides needed services and supports.
6. Effective service delivery and utilization management assures that individuals and their families receive services and supports that are appropriate to their needs.
7. Services and supports meet the highest standards of quality and accountability.

Goals, Objectives, and Action Steps

Goal 1: Successfully implement a recovery and resilience-oriented and person-centered system of services and supports.

Objectives:

1. ***Create awareness and understanding of recovery and resilience-oriented and person-centered principles and practices.***

Action Steps:

- a. Implement an educational campaign to increase awareness of key policymakers, state and local government officials, individuals and family members, public and private providers, and the general public.
 - b. Support peer-to-provider training and other learning opportunities for staff of the Department's central office, state facilities, and licensed public and private providers on how they might align their organizational cultures with the vision and services values.
 - c. Implement a variety of training opportunities designed to increase the knowledge and skills of staff at all levels of state facilities and community provider organizations in implementing recovery, resilience, and person-centered principles and practices.
2. ***Publicize the commitment of services system leaders to recovery and resilience-oriented and person-centered principles and practices.***

Action Steps:

- a. Celebrate successes and promote the vision of a system of services and supports that is recovery and resilience-oriented and person-centered.
- b. Provide executive recognition of individuals and organizations for their contributions to advancing the vision of the future services system in Virginia.

3. *Transform current services system policies and regulations, incentives, service structures, and practices to support implementation of a recovery and resilience-oriented and person-centered system of care.*

Action Steps:

- a. Adopt a state policy on self-determination, empowerment, recovery, and resilience.
- b. Implement a transformation initiative to support the Department's leadership and coordination of services system transformation activities and provide individual and provider recovery and resilience training.
- c. Incorporate recovery and resilience-oriented and person-centered principles in the revision of the Department's human rights and licensing regulations.
- d. Involve the Department's central office staff, state facilities, CSBs, and other public and private providers in an examination of how current practices for managing risk affect self-determination, empowerment, recovery, and resilience.
- e. Launch a demonstration project to implement recovery and resilience-oriented and person-centered principles and practices throughout the programming, funding, and operations of one or more CSBs.
- f. Support the efforts of state hospitals and training centers to develop and disseminate new knowledge on how to implement recovery, resilience, and self-determination principles in state facility settings.

B. Implementation of Self-Advocacy, Self-Determination, Recovery, Resilience, and Person-Centered Principles and Practices

Mental Health

The Virginia mental health system has been enhanced and improved through the involvement of well-informed individuals and their families. Such involvement at all levels of the services system has been and continues to be a priority of the Department. Federal Mental Health Block Grant funds are used to support numerous activities across the state to educate individuals and their families about mental illnesses and treatments. These activities have been accomplished through contracts with the

Virginia Human Services Training Center (\$74,928) to train individuals receiving services as peer counselors;

National Alliance for the Mentally Ill (NAMI)-Virginia to provide statewide education to individuals and their families (\$50,000);

Mental Health Association of Virginia to provide Consumer Empowerment Leadership Training (CELT) Leadership Academy training (\$75,000);

Parents and Children Coping Together (PACCT) to educate parents and caregivers of SED children across the state (\$75,000);

Virginia Organization of Consumers Asserting Leadership (VOCAL) to provide technical assistance to peer-run programs (\$62,718), VOCAL's Reach initiative to provide Wellness Recovery Action Plan training (\$50,000), and VOCAL's Consumer Network to build and strengthen a statewide peer network (\$75,000);

Contracts with six peer-run programs across the state to provide peer-operated programs and centers (\$291,860);

Family Support Services Project (\$32,500) in southwest Virginia; and Southwest Virginia Consumer and Family Involvement Project (\$42,500).

Summaries of project accomplishments follow.

The Virginia Human Services Training Center is located at the Piedmont Virginia Community College with support from the Region Ten CSB. The training is a collaborative effort of the Department, CSBs, Department of Rehabilitation Services, and the community college. Communities nominate individuals to be trained in the skills needed to provide peer counseling back at their home CSBs. Each year, approximately 15 individuals are trained.

NAMI-Virginia has conducted assessments of family education needs in Virginia and provided training across the state. Over 28 new or existing family education groups have been developed or supported to inform individuals and family members about mental illnesses and their treatments. Technical assistance was provided to 50 family education and support groups using programs such as Mutual Education, Support and Advocacy (MESA), NAMI's Family-to-Family, and NAMI Texas' VISIONS.

The Mental Health Association of Virginia has provided Consumer Empowerment Leadership Training (CELT) Leadership Academy training in all regions of the state. Through the CELT program, individuals from across the state have received specialized training in the skills needed to effectively represent services recipient issues on boards and committees.

The Virginia Organization of Consumers Asserting Leadership (VOCAL) is building a strong peer community across the state. VOCAL initiatives include training WRAP instructors across Virginia, providing technical assistance and training to six state funded peer-run programs in all regions, and building a new statewide peer network.

Parents and Children Coping Together (PACCT) has trained over 100 family members and caregivers of children with serious emotional disturbance. The Family Involvement Workshop provided information about the service system in Virginia and taught the skills needed to effectively access services for children in need. A Family Leadership train-the-trainer workshop was conducted to train family members in the skills needed to conduct their own Family Involvement Workshop. A toll-free telephone number has been maintained to provide information and referral for mental health services for children across the state. Quarterly newsletters concerning mental health services for SED children have been published and distributed across Virginia. With support from the Department, PACCT is evolving and is changing its name to the Federation of Families of Virginia to gain a stronger connection and name recognition with the federal organization of parents.

The Family Support Services Project was established to develop and assist family support groups with education, support, and advocacy. This effort is directed to family members of those with serious mental illness and involves close collaboration with CSBs in the southwest region and the Southwestern Virginia Mental Health Institute. Project activities include implementation of a toll-free information and referral line and "Ask the Doctor" videoconferences between support groups and the Institute.

The Southwest Virginia Consumer and Family Involvement Project is a peer-driven project, the purpose of which is to prepare individuals with mental illness to become meaningfully involved in the mental health system by providing education, advocacy, and support. Project activities are aimed toward increased individual and family participation in decision-making and policy formation, in service planning, and in the delivery and evaluation of publicly funded mental health services. These activities include the coordination of LEAP (Leadership-Empowerment-Advocacy Program) Training, MESA Training, Peer Counselor Training, and Community Integration Groups.

In addition to these initiatives, when one-time funds are available, the Department works with the MH Planning Council to support other projects that promote individual and family involvement and education.

The Department also has continued to support individual involvement in the annual meetings of the Virginia chapter of the United States Psychiatric Rehabilitation Association (formerly IAPSRs). Individuals from across the state are able to attend the annual meeting and learn about innovative services and opportunities to expand their involvement in transforming the services system.

Mental Retardation

Involvement by individuals receiving services and families is a critical component of all services supported through the Department. Individuals receiving services and families are involved in the development of Medicaid Waiver plans of care, and they must be part of the annual planning process for Waiver services. The Department provides technical assistance to all providers in techniques of person-centered planning.

Individuals receiving services and families are involved in the policy and planning process. All Part C workgroups and administrative committees include family members, and the oversight committee appointed by the Governor, the Virginia Interagency Coordinating Council, has several family members. The Mental Retardation Waiver Task Force, established in 2001 to rethink the services and direction of community-based Waiver services, includes individuals and families, as well as families of residents in training centers.

Since 2003, the Department has been involved in a grant project, New Voices, through the Virginia Board for People with Disabilities that assists individuals with developmental disabilities in Virginia to become self-advocates. The project is enabling individuals with mental retardation and developmental disabilities to assume greater roles in deciding their futures. At least one participant is a lifelong resident of a training center who is seeking to live in the community. In 2004, the Virginia Board for People with Disabilities approved funding for a community inclusion grant through which the Department oversees a process of awarding smaller mini-grants to agencies and providers around the state who have developed innovative ideas that use existing systems and resources to promote greater community inclusion opportunities for individuals with disabilities.

Each year, all CSBs give family satisfaction surveys to families of people with mental retardation receiving case management services. Families return the surveys directly to the Department and results are analyzed to determine individual or family member perceptions of services. Results are shared with each CSB.

Substance Abuse

Individual advocacy for substance abuse services has been slow to develop due to stigma, shame, and fear. Initially organized in 1997 as a grassroots advocacy organization, the Substance Abuse and Addiction Recovery Alliance (SAARA) of Virginia continues to make strong inroads in Virginia by establishing and supporting local affiliates. Now incorporated as a 501c3 nonprofit organization, the mission of SAARA of Virginia is to maximize "the power of the people to advocate for treatment and recovery in order to prevent the harmful effects of substance abuse upon families, businesses, and the community."

Membership is open to individuals and organizations. SAARA's goals include informing the public about the impact of addictions and the resources and services available for treatment and prevention; developing and sustaining SAARA as a viable organization; communicating with the

general public and legislative bodies; and becoming fiscally self-sustaining. As a part of its goal to become self-sustaining, its board of directors has received training in fund raising and is implementing strategies to encourage corporate memberships. SAARA publishes a quarterly newsletter, *The Recovery Advocate*, has established a website (www.saara.org), and conducts an annual conference for members and interested persons.

Goals, Objectives, and Action Steps

Goal 2: Increase opportunities for individual and family involvement.

Objectives:

1. ***Maintain current avenues for individual and family involvement, while seeking to widen the scope of individual involvement in all aspects of the mental health system.***

Action Steps:

- a. Continue to strengthen the Mental Health Planning Council's voice in system development.
- b. Provide funding to support individual and family involvement in restructuring and re-investment planning processes and meetings.
- c. Seek ways to build and link the network of parents of children and adolescents with mental health, mental retardation, and substance abuse service needs.
- d. Promote and seek additional funding for LEAP and the CELT Leadership Academy training to better prepare individuals and family members for meaningful roles in planning and policy making activities.
- e. Keep VOCAL and peer-run programs throughout Virginia fully informed about opportunities to be involved in systems change initiatives.

Goal 3: Improve opportunities for individual and family education and training.

Objectives:

1. ***Increase the number of individuals and family members who receive training.***

Action Steps:

- a. Contract with individual and family organizations to provide education training.
- b. Promote education and training opportunities through CSBs, NAMI, VOCAL and MHAV.
- c. Expand family psycho-education (e.g. MESA and Family-to-Family education) and recovery peer-to-peer education (e.g. VOCAL, REACH, CELT, LEAP, and VHST).
- d. Implement the evidence-based practice of family psycho-education in at least one CSB in each region.
- e. Support efforts of advocacy organizations to expand Consumer Empowerment and Leadership Training (CELT), including Advanced CELT Training.

Goal 4: Promote and support the implementation of mental health programs that foster empowerment, peer support, and recovery-based services.

Objectives:

1. ***Collaborate with the Mental Health Planning Council and other services system partners to transform the current system of services and supports toward a recovery orientation.***

Action Steps:

- a. Target Mental Health Block Grant dollars for transformation activities.

- b. Target CMHS Advocacy for Human Potential grant resources through mini-grants to CSBs and regions to support long- term transformation projects.
- c. Implement the MHST Real Choice System Transformation grant to enhance the state Medicaid program to be more recovery-oriented by adding the evidence-based practices of illness self-management, assertive community treatment, and supported employment to the array of Medicaid-covered services.

2. *Promote the establishment and expansion of peer-run programs throughout the state.*

Action Steps:

- a. Continue to enhance and strengthen Virginia’s statewide network of peer organizations and family alliances.
- b. Develop new and expand existing peer-run centers.
- c. Develop and implement a statewide recovery education program run by and for individuals receiving mental health services.
- d. Continue to fund and support the operation of a statewide network of local peer organizations that increase the voice and representation of individuals receiving mental health services and supports.
- e. Continue to fund a statewide recovery education program run by and for individuals receiving mental health services and supports.
- f. Promote and support the establishment of peer-run programs in each CSB service area.

Goal 5: Provide individuals and families with the opportunity, at the systems and individual levels, to determine the types of mental retardation services and supports they receive and to evaluate the quality of those services.

Objectives:

1. *Expand the number of individuals receiving services and families involved in the planning process.*

Action Steps:

- a. Conduct more “focus group” or regional meetings in targeted areas, rather than relying on centralized meetings that fewer people can attend, due to work schedules or other resources.
- b. Support the “New Voices” project to develop more direct input and understanding of the messages from individuals with mental retardation.
- c. Schedule a minimum of three focus groups annually, inviting individuals and families who represent different types of issues, e.g., access to supported employment services or supporting family members with a dual diagnosis.
- d. Review the number of individuals and families participating in training projects in which the Department participates.
- e. Continue training opportunities for provider and agency staff that include developing person-centered environments for individuals and their families.

2. *Assure greater opportunities for individual and family direction in their own services.*

Action Steps:

- a. Continue working with the Department of Medical Assistance Services and the Independence Plus workgroup to obtain federal approval for a self-determination-oriented Medicaid program and expand opportunities for individual and family participation in person-centered services through the MR Waiver.

- b. Determine the satisfaction of families and individuals who receive services through a survey method.

Goal 6: Reduce the stigma and shame associated with substance use disorders that inhibit people with substance use disorders from seeking help and restrict available resources to support treatment and prevention and increase the impact of individual experience on the service delivery system.

Objectives:

- 1. *Facilitate the development and growth of the Substance Abuse and Addiction Recovery Alliance (SAARA) as a fiscally independent organization with a strong, viable membership.***

Action Steps:

- a. Partner with SAARA in developing and implementing initiatives that will educate members of the general public as well as targeted groups, such as family members and physicians, about substance use disorders and evidence-based treatment.
- b. Continue to contract with SAARA to develop individually oriented products and services that foster advocacy in the community.
- c. Continue to provide technical assistance to SAARA by utilizing national and federal resources.
- d. Continue to support SAARA in pursuing and developing sustainable fiscal resources.

C. *Access to Services and Supports That Meet Individual Needs*

Olmstead Decision Implementation Update

In 1999, the United States Supreme Court issued a decision in the case of Olmstead v. L.C., 119 S. Ct. 2176 (1999). This case involved a challenge under Title II of the Americans With Disabilities Act (ADA), 42 U.S.C. § 12132, by two women with mental disabilities who lived in mental health facilities operated by the state of Georgia, but who wished to live in the community. The ADA prohibits discrimination in public services furnished by governmental entities (Title II, 42 U.S.C. § 12131-12165). Title II regulations issued by the U. S. Attorney General include an integration regulation stating: "A public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The most integrated setting is that which enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible. The U.S. Supreme Court held that Georgia had violated the ADA by forcing these women to remain in a state mental hospital after their treating professionals had determined that they were ready for discharge.

In the decision, the Court held that a state is required under Title II of the ADA to provide community-based treatment for persons with mental disabilities when:

The state's treatment professionals determine that such placement is appropriate;

The affected persons do not oppose such placement; and

The placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities.

Although the Olmstead case involved two individuals with a mental disability, the decision is broad in its scope and applies to all qualified persons with disabilities covered by the ADA. It applies to all qualified individuals with mental, physical, or sensory disabilities. It applies to individuals who are institutionalized or who are at risk of institutionalization.

The Olmstead decision does not prohibit institutional placement, but, in fact, recognizes it as the least restrictive setting for some individuals who cannot handle or benefit from community settings. Additionally, the decision affirms that there is no federal requirement that imposes community-based treatment of patients who do not desire it.

States must make reasonable accommodations in programs in order to provide community-based services to qualified individuals, unless doing so would fundamentally alter the services provided. This “fundamental alteration” standard is met if the state can demonstrate that it has:

- A comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and

- A waiting list that moves at a reasonable pace not controlled by the state’s efforts to keep its institutions fully populated.

In August 2003, the 70-member Task Force formed pursuant to Item 329M of the 2002 Appropriation Act submitted its Final Report to the Governor, the Joint Commission on Health Care, and the Chairmen of the House Appropriations and Senate Finance Committees. The Report includes a vision statement, a goals statement, issues, and 201 recommendations with implementation time frames and responsible entities, organized by topic.

On January 6, 2004, Governor Warner issued Executive Order (EO) 61, “The Olmstead Initiative,” establishing and specifying the responsibilities of a Community Integration Implementation Team comprised of 18 state agencies and four Secretariats, a Community Integration Oversight Advisory Committee comprised of a majority individuals with disabilities and family members and the balance comprised of advocates and providers, and a Director of Community Integration for People with Disabilities. Under EO 61, the Community Integration Implementation Team was charged to:

- Categorize recommendations into types of action needed to implement: administrative, regulatory, legislative and/or budget;

- Cost out and update recommendations; prioritize and prepare legislative and budget proposals for the Governor’s consideration; and

- Seek advice from and report annually to the Committee on the status of *Olmstead* implementation in the Commonwealth

The responsibilities of the Community Integration Oversight Advisory Committee under EO 61 were to:

- Oversee *Olmstead* implementation in the Commonwealth,

- Advise the Team,

- Receive annual reports from the Team, and

- Report their recommendations to the Governor by October 21, 2004.

On January 14, 2005, Governor Warner continued “The Olmstead Initiative” by issuing Executive Order 84, which maintains the same roles for the Committee, Team, and Director as EO 61. Additionally, the Committee and Team were instructed to “collaborate and, using a strategic planning process...update and prioritize the recommendations in the Task Force Report.” The Team’s report to the Committee and the Committee’s report to the Governor were also to include recommendations for six specific topics:

- Increasing membership of people with disabilities, family members, and surrogate decision-makers on state and local boards and commissions;

Establishing and maintaining waiting lists of residents, by disability, who are appropriate for discharge and want to be discharged from nursing facilities and assisted living facilities;

Assuring an appropriate statewide system for reporting allegations of abuse, neglect, serious injuries, and deaths by providers of community services and supports to people with disabilities;

Developing a statewide system of consistent rights notification that includes a means by which the quality of information given to such individuals and the consistency with which information is given are tracked;

Monitoring the quality and coordination of services provided to persons with disabilities, including a process by which complaints relating to the denial, quality, and coordination of services provided to persons with disabilities may be made by or on behalf of individuals with disabilities and resolved; and

Developing a coordinated reporting system across agencies to monitor the effectiveness of efforts to improve the quality and coordination of services provided to persons with disabilities consistent with the Americans with Disabilities Act and recommendations in the Olmstead Task Force Report, including a system to measure and evaluate the performance of the Commonwealth.

Thirty-four Task Force Report recommendations have already been implemented, including:

Creation of the Governor's Olmstead designee, stakeholder group, and interagency team;

Launch of the Virginia Housing Registry;

Home accessibility modifications programs;

Education of architects, contractors, and others in accessibility and universal design;

Legislation expanding newborn screening;

Development of a Waiver Choices brochure;

Increased oversight of community services; and

Targeting of grants to fund Olmstead solutions.

Substantial progress has been made on many other recommendations, including:

Funding to increase PACT programs, discharge assistance plans, crisis stabilization units, and community inpatient bed purchases for people with mental illness,

Funding 860 additional Medicaid waiver slots and two Regional Community Support Centers for people with mental retardation,

Funding 105 additional Medicaid waiver slots for people with developmental disabilities,

Funding new waivers for day support services and for people with Alzheimer's and dementia, and

Funding rate increases for Medicaid Mental Retardation Home and Community-Based Waiver and personal care providers, nursing facilities, and hospitals.

Additionally, the Virginia Board for People with Disabilities recently awarded a nursing home transition grant to identify people in nursing facilities who may want to be able to live in the community. The Department of Medical Assistance Services (DMAS) recently announced that it is issuing fast track regulations that would add transitional benefits (upfront household expenses) to all Medicaid waivers.

The Olmstead Advisory Committee's Second Annual Report to the Governor contained the following priorities.

TOP SIX PRIORITIES	
1	Increase all Medicaid reimbursement rates to include the maximum allowable cost of service; automatic cost of living adjustments (COLAs); geographical rate differentials; travel and transportation; staff training and supervision; and inflation. Ensure that caregiver pay rates are reflected. Reimburse Direct Support Professionals at higher pay and benefits for certifications and career enhancement. Increase rates for transportation services to adequately cover the cost of operations.
2	Increase the personal maintenance allowance to 300 percent of the monthly SSI payment limit in all Waivers.
3	Increase the availability of funded Medicaid Waiver slots for people on the urgent list as well as those wanting to leave institutions. Continue to eliminate waiting lists for Waivers and other supportive services; avoid future waiting lists by anticipating regular increases in need for services. Fund 25 percent of 2003 waiting list in 2005; 45 percent of 2004 waiting list in 2006; 65 percent of 2005 waiting list in 2007; 80 percent of 2006 waiting list in 2008; and 100 percent of waiting list, except those waiting 90 days or less, in 2009. Require DMAS to keep a waiting list of people in nursing facilities and ICFs/MR who are ready for discharge and who want to move. There should be no wait longer than 90 days for discharge for people living in any institution.
4	Continue to fund and develop community services to eliminate the state hospital discharge waiting lists.
5	Develop and fully fund incentives to attract and retain qualified candidates to disability fields of care.
6	Increase Medicaid financial eligibility to 100 percent of the Federal Poverty Level.
PRIORITIES 7 THROUGH 14 IN NO PARTICULAR ORDER	
Develop funding, fiscal and other incentives for providing and establishing new services, including employment and quality integrated community-based day support Medicaid-funded services.	
Include employment as an issue in discharge planning protocols for people wishing to work in the community.	
Promote recovery-oriented services designed to prevent institutionalization for adults with serious mental illness, including effective consumer-operated and peer services. Develop a mental health consumer group to mentor those seeking transitions.	
Establish and grant emergency regulatory authority for a revolving fund for people in institutions to use for utility and rent deposits and other upfront household expenses to enable them to move from institutions.	
Amend Va. Code § 54.1-3000 and other relevant sections (commonly known as the "Nurse Practices Act") and associated regulations to exclude personal assistants, respite workers and companion aides under direction of a consumer or his/her surrogate from the requirements of the Act. Model the amendment on provisions in the Kansas statute that permit attendants to provide activities if the activities may be performed by the individual if the individual were physically capable, and the procedure may be safely performed in the home.	
Fund the Brain Injury Waiver.	
Implement the Dementia Waiver.	
Assure state-level Consolidated/Housing Agency Plans identify persons with disabilities as a high priority housing need population. Mandate agencies, in allocating Section 8 voucher assistance, grant funds, low-and no-interest loans, and technical assistance, to assign high priority to these needs.	
HOUSING PRIORITIES	
Establish a state housing supplement program for people leaving state mental health, mental retardation, nursing and assisted living facilities. Develop State and local consensus on strategies to increase landlord participation in the program, especially outside areas of low-income and minority concentration.	
Require landlords to treat as income the value of Housing Choice Vouchers and other public benefits for people with disabilities.	
Develop a legislative proposal requiring owners and managers of fully accessible housing to post advance notice of unit availability before making units available on open market.	

Assure State level Consolidated/Housing Agency Plans identify persons with disabilities as a high priority housing need population. Mandate agencies, in allocating Section 8 voucher assistance, grant funds, low-and no-interest loans, and technical assistance, to assign high priority to these needs.
Dialogue with local governments and public housing agencies on how to prioritize housing needs of people with disabilities in allocating locally administered housing subsidies and resources. Train CHDOs/other housing organizations/providers, CSBs, CILs, DSBs, and AAAs on best practices in building and sustaining local affordable and accessible housing partnerships. Determine on a regional basis the local capacity for delivering affordable and accessible housing. Meet with CSBs, CILs, DSBs, and AAAs to understand differences in local and regional housing needs and strategies and determine local and regional prioritization of gaps that State resources should address.
Examine establishing alternatives to sole reliance on the Auxiliary Grant program.
Educate local governments, the General Assembly, and the public about the negative impacts of many local land use regulations and practices on creating affordable and accessible housing.

Special Populations Issues

Children and Adolescents Who Have Serious Emotional Disturbances, Cognitive Developmental Delays, or Substance Use Disorders: *Mental Health: A Report of the Surgeon General* cites concerns about inappropriate diagnoses of children's mental health problems. Too often, children with mental health problems do not receive services until they end up in a secure setting such as a hospital, detention center, jail, or a state juvenile correctional facility. The Report identified the following mental disorders with their onset in childhood and adolescence: anxiety disorders, learning and communication disorders, attention-deficit and disruptive behavior disorders, mood disorders (e.g. depressive disorders), autism and other pervasive developmental disorders, eating disorders, tic disorders, and elimination disorders.

According to the *Surgeon General's Report*, both biological factors and adverse psychosocial experiences during childhood influence but do not necessarily "cause" mental disorders in children. Their effect depends on individual differences among children, the children's ages, and whether these factors or experiences occur alone or in combination with other risk factors. The *Report* cites the following risk factors for developing mental disorders or experiencing social-emotional problems:

- Prenatal damage from exposure to alcohol, illegal drugs, or tobacco;
- Low birth weight;
- Difficult temperament or and inherited predisposition to a mental disorder;
- External risk factors such as poverty, deprivation, abuse, or neglect;
- Unsatisfactory relationships;
- Parental mental disorders; and
- Exposure to traumatic events. (*Surgeon General's Report*, p. 129)

A growing body of empirical evidence estimates a prevalence rate as high as 50 percent for the co-occurrence of alcohol and other drug use among adolescents with mental health disorders. Recent studies suggest that these adolescents have special treatment needs, including:

- Attention to developmental and other characteristics of adolescents,
- A treatment focus that examines and involves the adolescent's social and familial networks,
- The adaptation of clinical interventions for adolescents with dual diagnoses, and
- The need for services to be coordinated and integrated across multiple systems and points of contact. (Petrila, Foster-Johnson, and Greenbaum, 1996)

Coordinating mental health and substance abuse systems of care would address the complex needs of adolescents with both problems. Service needs for adolescents coping with co-occurring disorders include crisis intervention, inpatient programs, residential treatment programs, day treatment programs, and outpatient counseling. (Fleisch, 1991) The Department has typically addressed the needs of children according to the specific disability area in which the child entered services. Nationally, as well as in Virginia, increasing emphasis is being given to integrating treatment services and supports for this population. Regardless of how their needs are identified in a system of care, children and adolescents should have access to mental health and substance abuse prevention services, adequate assessments, evaluation and diagnosis, and appropriate treatment, when needed.

In 2003, among the 2.7 million U.S. children aged 4-17 years for whom parents reported definite or severe emotional or behavioral difficulties (5 percent of all children in that age group), nearly two thirds had had a contact with a mental health professional or a general physician or had used special education services for those difficulties. More specifically, 44.5 percent had received services from a mental health professional (i.e., psychiatrist, psychologist, clinical social worker, or psychiatric nurse) during the preceding 12 months, 39.1 percent had received services from a general physician (i.e., a physician in general practice, pediatrics, family medicine, or internal medicine) for an emotional or behavioral difficulty during the preceding 12 months, and 22.6 percent had received special education services for an emotional or behavioral difficulty. (Simpson, Bloom, Cohen, Blumberg, and Bourdon, 2005) Although a child may have received more than one type of service, the magnitude of need and the potential for service gaps and fragmentation across the various child-serving systems has been identified in the President's New Freedom Commission report (p 3, p 27).

While progress has been made with system of care initiatives to improve access to services, most notably, the Comprehensive Services Act, Virginia's service system for children continues to be fragmented. There continues to be an over-reliance on residential care and inadequate community services to help parents keep their children at home. Parents are forced to move from agency to agency seeking the coordinated package of services their children need.

The 2004 Appropriation Act included budget language (Item 330-F) directing the Department and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, CSBs, and court service units, to develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children to mental health, mental retardation and substance abuse services. The Department established a workgroup representing CSBs, state agencies, parents, and other partners to identify service needs and develop the *Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Services for Children, Adolescents and Their Families*. Budget item 330-F requires an annual report to the chairmen of the Senate Finance and House Appropriations Committees. The most recent report (August 2005) included the following recommendations:

- Build a statewide family support coalition designed to link existing family support organizations and groups that provide services, supports, and advocacy to families who have children with mental health, mental retardation, substance abuse, chronic illness, disabilities, and other special needs.

- Expand training and education opportunities with payback provisions for new clinicians where there is an undersupply of specialists (child psychiatrists or child psychologists) and provide ongoing behavioral health care training for existing staff and health care professionals, such as pediatricians, family practitioners, and primary care physicians.

- Fund evidence-based initiatives to expand systems of care in selected localities.

This report called on the Department to adopt children's behavioral health as a very high priority in its policies, plans, and services, coordinate and plan for children with behavioral health needs with other state agencies, and provide guidance to help local offices maximize third party funding for children's behavioral health services. It also recommended that the Department make prevention activities a central focus of its policies and plans regarding children's behavioral health services, develop case management standards for CSBs throughout the state, and take initial steps to change the term "case management" to "care coordination." Other report recommendations focused on:

Using Comprehensive Services Act funding flexibly and creatively to develop additional services, including pilot projects to serve children with behavioral health needs more effectively at the same or lower cost;

Suspending rather than ending Medicaid benefits when youth enter detention and prison facilities; and

Expanding the membership of the Child and Family Behavioral Health Policy and Planning Committee in the FY 2007-2008 biennium budget language reauthorizing the Committee.

Elderly Individuals Who Have Mental Illnesses, Mental Retardation, or Substance Use Disorders:

Nationally, the geriatric population accounts for about 12.4 percent of the total population. The anticipated impact of aging "baby boomers" will increase this proportion to 20 percent by 2030. (Federal Interagency Forum on Aging, Korper and Council, 2002) These changes are likely to place increased pressure on health care services and the demand for social services. It will be important for the Department and the services system to plan for the accelerated growth of the elderly population and their proportionately greater and more expensive healthcare needs.

According to *Mental Health: A Report of the Surgeon General* (1999), almost 20 percent of the population 55 and older, or an estimated 312,238 Virginians (2003 Final Estimated Population), experience specific mental disorders that are not part of "normal" aging. Best estimate one-year prevalence rates for specific mental disorders, based upon epidemiological catchment area information described in the *Surgeon General's Report*, follow.

Estimated One Year Prevalence Rates in Virginia of Mental Disorders Not Associated with Aging

Disorder	Percent	Number	Disorder	Percent	Number
Any Anxiety Disorder	11.4	35,595	Somatization	0.3	937
Any Mood Disorder	4.4	13,738	Severe Cognitive Impairment	6.6	20,608
Schizophrenia	0.6	1,873	Any Disorder	19.8	61,823

Mental Health: A Report of the Surgeon General, Chapter 5 Older Adults and Mental Health (page 336),
Source of prevalence estimates: D. Regier and W. Narrow, personal communication, 1999.

Abuse of alcohol and legal drugs, prescription and over-the-counter, is a serious health problem among elderly Americans, affecting up to 17 percent of adults aged 60 or older. Approximately half of older adults are light or moderate drinkers and the interactions between alcohol and other drugs and multiple drug use may result in significant problems for them. (Adams, 1997, CSAT, 1998) Alcohol and drug use may elevate older adults' already high risk for injury, illness, and socioeconomic decline. (Tarter, 1995) For example, elderly individuals who "self-medicate" with alcohol or prescription drugs are more likely to characterize themselves as lonely and to report lower life satisfaction. (Hendricks et. al., 1991) Elderly women with alcohol problems are more likely to have had a problem-drinking spouse, to be widowed, to be depressed, or to be injured in falls. (Wilsnack and Wilsnack, 1995)

Alcohol and prescription drug misuse and abuse occur among elderly individuals for a variety of reasons. More drugs are prescribed for more chronic illnesses, and elderly persons may misuse drugs due to confusion, lack of judgment, or miscommunication. Because of insufficient knowledge, limited research data, and hurried office visits, health care providers tend to overlook substance abuse and prescription drug misuse among elderly individuals, mistaking the symptoms for those of dementia, depression, adverse drug reactions, or other problems common to older adults. In addition to the psychosocial issues that are unique to elderly persons (unresolved loss, progressive family and social isolation, sensory deterioration), age-related biomedical changes influence the effects that alcohol and drugs have on the body and may accelerate the normal decline in physiological functioning that occurs with age. (Gambert and Katsyoannis, 1995)

The *Surgeon General's Report* estimates that an *unmet* need for mental health services may exist for up to 63 percent of adults aged 65 years and older with a mental disorder (p. 341). Also, many elderly individuals need treatment for alcohol and drug abuse disorders and do not receive it; they may be more likely to hide their substance abuse and may be less likely to seek professional help. (CSAT, 1998) Nationally, annual substance abuse treatment admissions among persons 55 or older decreased by 3 percent from 1994 to 1999. During that same time period, U.S. alcohol abuse admissions among older adults declined, but admissions for misuse of illicit drugs increased. (DASIS, 2001) CSB 4th quarter performance contract utilization data indicate that individuals age 65 and older have consistently accounted for less than one percent of the individuals served through Virginia's publicly-funded system of care (510 individuals [0.91 percent] in FY 1993, 512 individuals [0.78 percent] in FY 2000).

The provision of mental health, mental retardation, and substance abuse services to elderly individuals is complicated by the lack of providers trained to serve this population and the limited number of specialized community-based programs in Virginia. The growing need to better serve elderly persons, including those with mental disabilities, represents a shift in this culture's perspective on aging. Where society once assumed that the geriatric population required no more than custodial or end-of-life care, increased longevity; a renewed respect for the social, political, and economic contributions of this population; and the demand for more appropriate treatment choices by individuals who receive services have placed pressures on service delivery systems to develop new treatment models. Treatment models for elderly persons with must be well coordinated, respond to the unique needs of a population with growing health issues, and provide services that promote new roles for individuals who seek to continue as productive members of their communities.

Integrating behavioral healthcare into primary care and other generalist settings will benefit elderly persons with substance use disorders or milder cases of substance dependence. Clearly, a great number of these individuals could be identified through substance screening procedures in primary care or other generalist settings and many could benefit from brief interventions delivered by physicians, nurses, pharmacists, and social workers who interact with them on a regular basis, sometimes in their own homes.

Individuals With Mental Illnesses, Mental Retardation, or Substance Use Disorders Who Are Involved in the Criminal Justice System: According to research cited in the President's New Freedom Commission report, about seven percent of all incarcerated individuals have a serious mental illness, a rate that is about three to four times that of the general U.S. population. The Report states that those individuals who come into contact with the criminal justice system are often poor, uninsured, disproportionately representative of minority populations, homeless, and living with co-occurring substance use disorders and mental illness. They are likely to continually recycle through the mental health, substance abuse, and criminal justice systems. When they are incarcerated, these individuals frequently do not receive adequate mental health services and have difficulty re-entering and reintegrating into the community after discharge

because many of them lose income supports and health insurance benefits. A similar situation exists for youth with serious emotional disturbances who are in the juvenile justice system.

To appropriately address the needs of this population, it is imperative to overcome, to the extent possible, the criminalization of adults with serious mental illnesses and youth with serious emotional disturbances by:

- Fostering the development community-based forensic evaluation and treatment services for those individuals who cannot be diverted from criminal justice system involvement;

- Reducing or eliminating prolonged waits for hospital admission for forensic evaluations and treatment that must be accomplished on an inpatient basis; and

- Defining improved methods for the delivery of a satisfactory array of psychiatric and substance abuse treatment in jail settings

Mental health, mental retardation, and substance abuse treatment services for individuals involved in Virginia's criminal justice system should be a community-focused endeavor, whenever possible. While there will always be a subgroup of jail residents who will require acute inpatient treatment, many inmates with mental health or substance use disorders can be served on-site in jail settings, provided that the necessary and appropriate services and supports are available in these locations. The Department is committed to developing an appropriate continuum of community-based solutions to resolve the problem of prolonged waiting times for admission of jail inmates for treatment at some state hospitals. However, sufficient resources necessary for such interventions do not exist. Virginia's efforts to date fall short of the mental health and substance abuse service needs of individuals in Virginia's criminal justice system.

The Department supports a number of programs providing mental health and substance abuse services for adults in local and regional jails and children and adolescents in juvenile detention centers. CSBs provide emergency services, including evaluations and preadmission screening for hospitalization, to individuals in local and regional jails and juvenile detention centers. CSBs also conduct non-emergency evaluations, including evaluations of competency to stand trial, criminal responsibility, and waivers of juvenile court jurisdiction. The Department uses federal SAPT block grant funds to support substance abuse case management services in local jails. Three CSBs receive funds to provide intensive substance abuse treatment patterned after offender-based therapeutic communities in separate jail living areas. Many CSBs provide mental health and substance abuse services to the offender population through local initiatives developed jointly with local and regional jails and juvenile detention centers. These services include: individual and group mental health and substance abuse counseling; psychiatric services, including medication; and restoration to competency.

CSBs also provide services through 16 adult and eight juvenile drug courts to non-violent felons who are offered this as an alternative to incarceration and treatment in jail. In addition, three localities operate family drug courts and one operates a court specifically for DUI offenders. Drug courts combine long-term (12-18 months), strict, frequent supervision by probation staff, intensive drug treatment by clinicians, and close judicial monitoring by the court.

The *Code of Virginia* requires that CSBs maintain written agreements with courts and local sheriffs relative to the delivery and coordination of services (§37.2-504). While these agreements need to be strengthened and enhanced in areas such as pre-release planning, communications, and continuity of care to assure rapid connection to community services upon release, they are critically important because statutory responsibilities for the provision of treatment services to adult and youth offenders are not defined clearly. Currently, no entity at the state or local level has clear responsibility for providing these services to adult or youth offenders. By statute, sheriffs must provide all necessary health care for jail inmates. U.S.

Supreme Court rulings and other legal precedents have verified that mental health care is a part of general health care for jail inmates. However, there is no requirement that jails must provide their own mental health and substance abuse services, as there is for the Department of Corrections. The Virginia Administrative Code, 6VAC15-40-1010, requires jail operators to have written policies in place, including agreements with either CSBs or private contractors to provide mental health services to inmates. Specific standards for the provision of mental health and substance abuse services in Virginia jails need to be included in the Virginia Administrative Code as a first step toward insuring improved access to treatment in local correctional settings.

Standards should also be established that identify the types of mental health and substance abuse services that should be available to adult and youth offenders, both in custody and in the community. These standards should address the need for the following services:

- Assessments to determine the presence of any mental illness, serious emotional disturbance, or substance use disorder and the most appropriate service dispositions for specific offenders;
- Diversion services for nonviolent adult and youth offenders;
- Treatment services provided in jails and detention centers; and
- Post-release treatment services, including specialized services such as supervised living programs.

Virginia needs to take advantage of community-based options to reduce demand on and prevent readmission of individuals involved with the criminal justice system to state hospitals. These include development of jail-based MH/SA teams to improve access to treatment, increased access to medications in jail settings, and development of appropriate community-based care for individuals who do not present public safety risks. Virginia also needs to improve the process of managing insanity acquittees who have been conditionally released and expand the capacity of CSBs to provide restoration to competency services in jails and community settings. These options have been of particular interest to various legislative committees and study groups for the past five years. Members of the Behavioral Healthcare Subcommittee of the Joint Commission on Health Care and the Senate Finance Public Safety Subcommittee are reviewing forensics programs that are operated by the Department. These and other stakeholders also are reviewing jail diversion strategies and other approaches to prevent the unnecessary involvement of individuals with mental illness, mental retardation, or substance use disorders with the criminal justice system and to promote optimal access to community-based treatment, whenever possible.

State hospitals provide the following services to adult and juvenile offenders:

- Evaluation of competency to stand trial,
- Evaluation of criminal responsibility,
- Emergency inpatient treatment prior to trial,
- Treatment to restore competency to stand trial,
- Emergency treatment after conviction and prior to sentencing, and
- Emergency treatment after sentencing but prior to transfer to the Department of Corrections.

For many years, state hospitals have maintained waiting lists for the admission of forensic patients for evaluation and treatment. There are approximately 30 to 40 persons waiting for admission at any given time. Approximately 35 percent of the individuals in state hospitals have been admitted from courts and jails or juvenile detention centers for treatment or evaluation. Roughly 20 percent of these individuals have an active status as pretrial or post sentence jail inmates and 15 percent have been committed to the Department after being found not guilty by

reason of insanity. In FY 2005, 1,236 adult jail inmates and juvenile detention center residents were treated or evaluated in state hospitals.

Individuals Civilly Committed to the Department as Sexually Violent Predators: Sexually violent predators are convicted sex offenders who are civilly committed to the Department at the end of their confinement in the Department of Corrections because of their histories of habitual sexually violent behavior and because their ability to control their violent tendencies is compromised by the presence of a “mental abnormality” or “personality disorder”. These individuals are predominantly male, on average about 40 years old. They have long histories of sexually abusing children and adults and have shown very limited ability or willingness to abstain from committing sexual offenses.

The enactment of legislation creating a civil commitment program for sexually violent predators (SVP) mandates the Department to open and operate a civil commitment program for persons found to be sexually violent predators, as defined in §37.2-900. A new behavioral rehabilitation facility, the Virginia Center for Behavioral Rehabilitation (VCBR), is providing treatment services to individuals civilly committed as sexually violent predators. The VCBR treatment program provides individualized treatment in a secure environment. International experience with this population supports the use of a rehabilitation approach that uses cognitive-behavioral principles focused on relapse prevention. Treatment involves multiple, daily group sessions, individual behavioral therapy, vocational training, and work therapy and programs, as appropriate. Direct care staff work with clinicians to create an environment that challenges deviant and criminal thinking and behavior while reinforcing appropriate behavior.

VCBR is currently located on the North Campus of the Petersburg campus, where two vacant buildings were retrofitted to accommodate treatment and security needs. This facility is too small for the long term. It lacks sufficient program and treatment space, offers residents less freedom than they had in prison, and has high staffing costs. Two site location studies for the SVP program conducted by the Department and DOC in 1999 and 2002 recommended the construction of a new facility financed under the Public Private Educational and Infrastructure Act of 2002 (PPEA). The 2005 Virginia Acts of Assembly, Chapter 951, authorized the Department, with the concurrence of the Secretary of Health and Human Resources, to enter into a comprehensive agreement pursuant to the PPEA for the design and construction of a permanent facility for the sexually violent predator program.

Individuals Who Have Co-Occurring Mental Retardation and Mental Illnesses (MR/MI): The National Association for the Dually Diagnosed (NADD) has broadly defined MR/MI as “the co-existence of the manifestations of both mental retardation and mental illness.” Persons with MR/MI can be found at all levels of mental retardation (mild, moderate, severe, profound) and can have the full range of psychopathology that exists in the general population. Estimates of the frequency of MR/MI vary widely in the published clinical literature; however, many professionals estimate that 20-35 percent of all persons with mental retardation have a psychiatric disorder. There are two major sub-groups with very different treatment needs.

Individuals who typically have a serious mental illness and who function at the mild or moderate level of retardation (MI/MR) – This group most often resides in the community and enters the service system because of challenging, difficult-to-manage behaviors that may pose a threat of serious harm to themselves or others. Some may be at increased risk for admission to a state hospital because they require specialized supports in a secure environment.

Individuals who have severe or profound mental retardation and a serious mental illness (MR/MI) – This group is more likely to be receiving care in an institutional setting, whether in the community or in a state training center.

Service providers for both groups must be knowledgeable and skilled in diagnosis and treatment or habilitation of both mental illness and mental retardation.

Families and individuals receiving mental retardation services and supports often are not aware that they can have diagnoses of mental retardation and mental illness, and they sometimes fail to recognize the signs and symptoms of mental illness. This lack of awareness increases the likelihood that they will cycle between the mental health and mental retardation service systems and face multiple barriers to accessing the services and supports they need.

Providing appropriate treatment for this population has been recognized as problematic in all states. Virginia does not have a systematic approach for meeting the needs of this population. The current service delivery system is organized by program area (MH, MR, or SA), with staff training and expertise typically limited to one program area. There also is a lack of community-based expertise in diagnosing, treating, and supporting individuals who require specialized assistance. Nevertheless, there are pockets of excellence in every state, including Virginia, which could be replicated.

In July 2002, the Department established a statewide MR/MI Steering Committee, which is comprised of representatives from CSBs, state hospitals, training centers, family members, and private providers. This group is examining the treatment needs of this population and exploring potential strategies for more effectively using current resources and building capacity within the system. Regional teams that mirror the steering committee are identifying current service gaps and disseminating knowledge about “best practices” and model programs already in existence. Teams also are identifying alternative funding sources (e.g., start-up or demonstration grants) and developing effective incentive plans for system change. Based on case reviews, the Northern Virginia MI/MR Workgroup developed clinical profiles of this population. The workgroups used these profiles to identify the following service enhancements that are critical to achieving successful outcomes:

- Formal agreements for collaboration and jointly shared responsibility between mental retardation and mental health services from the Department and CSBs;
- Collaboration among Department and CSB mental retardation and mental health agencies and private providers of residential and day or vocational services;
- Flexible funding, with immediate availability of funds based on levels of support needed rather than on diagnosis;
- Specialized supervision and well-trained staff that receives specialized training for all personnel at the clinical, medical, managerial, and direct services levels in MR/MI issues;
- Accurate psychiatric assessment and diagnoses;
- Interdisciplinary assessment involving staff of mental retardation and mental health agencies;
- Psychiatrists with previous knowledge of and training in MR/MI issues;
- Intensive case management, with smaller case loads allowing the case manager to take a much more active role in helping the individual develop and maintain everyday life skills and build natural circles of support;
- Sufficient staff resources in residential and day or vocational locations to allow for one-to-one staffing during crisis and stabilization periods;
- Strategies that address crisis situations as an integral part of an overall treatment or discharge planning;

Significant behavioral consultation hours with more hands-on care than the typical behavioral consultation;

Partial hospitalization and crisis stabilization for the relatively few individuals who need this level of care to avoid removing them from their homes and provide an option to inpatient hospitalization or institution-based care with minimum bureaucracy;

Specialized outpatient services;

A Program for Assertive Community Treatment (PACT) model specialized in MR/MI issues, and mobile crisis intervention teams of clinical and direct care professionals with expertise in MR/MI issues;

Suitable day placements to meet individual needs, including vocational and non-vocational options, as well as community college life skills degree programs;

Community residential placement options and in-home supports with a full range of alternatives (e.g., group homes, specialized foster care, 2-3 bed homes, supervised apartments, mentor roommates, and Life Coaches) and financial incentives for residential private providers to keep beds available when individuals are placed out of the home for short durations during crises;

Prioritized review of requests and applications for MR Waiver funding for individuals with MR/MI issues;

Frequent coordination and follow-up by CSB case management staff with residential and vocational placements to ensure adherence to treatment plans and to prevent slippage and crisis episodes; and

Family and individual education and support groups to recognize dual diagnosis, learn more about treatments, and offer support for dealing with the challenges of a dual diagnosis.

The Northern Virginia MI/MR Workgroup concluded that: “Services should be based upon individual needs and supports rather than disabilities, thus avoiding ‘problem shifting’ that occurs between MR and MH agencies. Much can be accomplished through collaboration with existing community resources rather than creating new resources in response to present limitations of single MR or MH service sectors.”

Individuals Who Have a Co-Occurring Substance Use Disorder and Mental Illnesses: Co-occurring substance use disorders and mental illnesses are characterized by the simultaneous presence of two independent medical disorders – psychiatric disorders and alcohol and other drug use disorders. Co-occurring disorders can occur at any age. Of those Virginians with an addictive disorder, 42.7 percent or 238,098 individuals also had a least one mental disorder during the 12-month period, according to the *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders*.

Co-occurring substance use disorders and mental illnesses are increasingly associated with negative outcomes. (RachBeisel, Scott, and Dixon, 1999) Research shows that these individuals are susceptible to poor functioning and clinical outcomes including:

More severe illness symptoms;

Increased hospitalization;

Decreased social functioning and non-compliance with treatment regimes;

An elevated risk of contracting HIV and hepatitis diseases;

Greater difficulty gaining access to health services; and

Increased risk for violent behavior.

Substance use also adversely affects the course and outcome of mental disorders for individuals with serious mental illness.

A number of studies have shown that co-occurring disorders are associated with increased costs of health services, mainly due to an increase in the use of acute psychiatric services, longer average length of stay in hospitals, and higher hospital admission rates. (AAP, 2000, Leon 1998, Dickey et al. 1996, Bartels et al. 1993, Drake et al. 1991, Lyons and McGovern 1998) Hoff and Rosenheck (1998) investigated the cost of treating substance abuse among patients with and without co-occurring disorders and found that individuals who were dually diagnosed had increased service utilization and cost regardless of which diagnosis was designated as the primary disorder. The public system faces difficult questions in setting appropriate goals and using resources wisely since substance abuse tends to increase expensive service utilization. (RachBeisel and Dixon, 1999)

Integrated treatment, as opposed to sequential or parallel forms of treatment, offers the most positive outcomes for individuals experiencing co-occurring disorders. (RachBeisel, Scott, and Dixon 1999; Drake et al., 2001, Schneider 2000, Drake and Wallach 2000) A 2002 SAMHSA report to Congress on co-occurring disorders cited the following practices as having the most positive outcomes for persons with co-occurring disorders.

- Integrated treatment models

- Use of integrated assessments

- Programs of assertive community treatment (PACT)

- Modified therapeutic communities

- Motivational interviewing/enhancement to promote engagement in the therapeutic process and enhance positive behavioral change

The following successful models that incorporate evidence-based treatment practices for individuals with co-occurring disorders have been developed and implemented.

Motivational interviewing, either alone or coupled with other techniques such as Cognitive Behavior Therapy and Family Intervention, is effective for treating persons with co-occurring disorders of schizophrenia and substance use. (Graeber et al. 2003, Barrowclough et al. 2001)

The *New York Model* of treatment is based on symptom multiplicity and severity, rather than on specific diagnoses. In this model, the appropriate service level (consultation, collaboration, and integrated services) is matched to the corresponding severity level to improve outcomes. (SAMSHA 2002, NASMHPD and NASADAD, 1998)

The *Comprehensive, Continuous, Integrated System of Care (CCISC)* is designed to be an accepting umbrella for all best practices in the treatment of individuals with co-occurring disorders. It incorporates the principles of integrated system planning; uniform program capability in dual diagnosis; universal practice guidelines; dual competence; concurrent treatment for simultaneous primary disorders; ease of access; treatment matching to subtypes of dually diagnosed individuals; utilization of parallel phases for treatment planning; readiness stages are not a barrier; treatment over time; and maintaining continuity of relationships with clinicians. (Minkoff, 1989, 1991, 2000, 2001)

Individuals with co-occurring substance use disorders and mental illnesses challenge the treatment system. Three major systemic barriers restrict services to persons with co-occurring disorders – restricted services funding, the lack of specifically designed programming, and lack of trained professionals. The Department must ensure that there is a collaborative and integrated response to the needs of these individuals. In 2004, The Department was awarded a

federal grant, State Incentive Grant for the Treatment of Persons with Co-occurring Substance Related and Mental Disorders (COSIG). The grant is supporting enhancements to the data infrastructure capacity for Virginia's public substance abuse and mental health system that will facilitate reporting of the co-occurring indicator for the Substance Abuse Prevention and Treatment and the Mental Health Performance Partnership Grants. The three-year grant involves 11 CSBs and will validate instruments for the screening of co-occurring disorders at the pilot sites, build capacity of the existing infrastructure by documenting the knowledge and skills of the current workforce; and provide training delivered by nationally recognized experts on evidence-based and culturally competent treatment practices for individuals with co-occurring disorders. In addition, the Department, in collaboration with the Department of Medical Assistance Services, was selected by the Substance Abuse and Mental Health Services Administration (SAMHSA) to participate in a national policy workshop in January 2005 to explore the feasibility of accessing Medicaid funding to support treatment for substance use disorders for individuals whose mental health treatment is supported by Medicaid.

Despite these considerable efforts, Virginia does not have a distinctive, planned, comprehensive and coordinated approach to delivering services to individuals with co-occurring disorders. Statutes and regulations governing the use of the Mental Health Performance Partnership Grant include services for dually diagnosed individuals, however these funds constitute only 2 percent of Virginia's allocation to CSBs. Through the COSIG grant, the Department is working to establish a comprehensive approach for technology transfer for both central office and CSB staff that will promote consensus and evidence-based approaches in treatment delivered to individuals with both mental illnesses and substance use disorders.

Individuals Who Are Deaf, Hard of Hearing, Late Deafened, or Deafblind: The Department's Advisory Council for Services for People Who Are Deaf, Hard-of-Hearing, Late Deafened, or DeafBlind (Advisory Council), composed of service providers and state agency representatives, is charged with assessing critical needs for this population, providing service oversight, and recommending future direction for service improvements and development in all three program areas. The Advisory Council has noted that hearing loss affects 8.6 percent of the general population. Between five and 10 percent of these individuals also experience a loss of vision. Research generally suggests that the prevalence rates for serious mental illness within the deaf, hard of hearing, late deafened, and deafblind populations are consistent with those found in the general population. Some studies suggest a higher prevalence rate for adjustment and personality disorder, emotional or behavior dysfunction, and substance use disorders. Contributing factors to this may include isolation due to communication barriers, lack of family support, underemployment, late onset of hearing loss, and lack of social identification.

Communication barriers associated with hearing loss also prevent access to CSB programs, resulting in the need for specialized and accommodated services for this population. The Department is committed to improving the capacity of the service system to address the communication and cultural access needs of this special population to ensure availability and access to needed specialized resources, professionals, support services, and technical assistance on a regional basis. Two years ago, the Advisory Council identified the following issues for action during the next three biennia:

- State facilities and CSBs could benefit from additional technical assistance resources to address the communication and cultural needs of this population;

- Regional programs need additional resources to meet the service needs of this population; and

- Inter-regional collaboration is needed to ensure the continuity of care and the effective provision of mental health, mental retardation, and substance abuse services.

Community Infrastructure and Services Capacity Development in Response to Documented Demand

The President's New Freedom initiative, along with ongoing Olmstead concerns, will continue to emphasize the development of community services. Communities lack basic mental health, mental retardation, and substance abuse services capacity to address existing demand and anticipated population growth. As state general funds have remained static and costs have increased, treatment capacity is declining, particularly for individuals who are not eligible for Medicaid. This has further limited the service system's ability to meet demands for services.

The Department's ongoing collaborative efforts with CSBs and other stakeholders to transform the mental health, mental retardation, and substance abuse services system will increase the need and demand for existing and new types of community services. As part of this transformation, CSBs and regional consortia of CSBs need to acquire the requisite capacity to manage their utilization of state facility and community inpatient psychiatric beds. This will require increased staff and community capacity to improve early screening, assessment, and clinical practice patterns and conduct extensive and complex utilization management and review activities. Investment in building the system's capacity to perform these activities will result in much more effective and efficient use of expensive and scarce state and local hospital beds.

Additionally, to support community capital infrastructure and capacity development, CSBs need funding to:

- Purchase, renovate, or construct transitional housing and other community-based diversion programs,
- Provide for one-time program start-up costs;
- Retool existing services based upon evidence-based and best practices and;
- Leverage other public and private resources to expand community services.

Investment of start-up funds to develop community capital infrastructure, implement new services technologies, and retool existing services will pay off in decreased demand for state facility services, greater access to more efficient and effective alternative community-based services and supports, and positive individual outcomes. Dedicated resources to support community infrastructure investment are not currently available to the services system.

Increasing demands have been placed on the public services system and local hospital emergency rooms as private insurance benefits for behavioral healthcare continue to deteriorate, Medicaid and insurance reimbursement rates fail to cover even direct costs for covered services, and the number of uninsured Virginians seeking behavioral health services continues to increase. Some private providers are either closing beds or no longer serving publicly funded individuals because third party reimbursement rates do not cover the cost of providing their services. In addition, the overall number of inpatient beds has declined.

The U.S. Census Bureau's Current Population Survey, 2003-2005 Annual Social and Economic Supplements, estimates that the three-year (2002 to 2004) average percentage of Virginians without health insurance coverage is 13.6 percent (90 percent confidence interval of 0.8). In 1996, the Joint Commission on Health Care conducted a detailed analysis of the insurance status of Virginians. A statewide survey sponsored by the Virginia Health Care Foundation found that approximately 13 percent of Virginia's population was uninsured and 19 percent of children, ages 0-19, were uninsured. In comparison with a similar survey conducted in 1993, the Joint Commission found that while the total number of uninsured persons had remained relatively constant, there was a substantial increase in the percentage of uninsured Virginians who earned over \$50,000 per year and in the percentage of individuals who were employed full-time. (Joint Commission on Health Care, 1997)

The lack of health insurance parity for the treatment of mental illnesses and substance use disorders forces many persons who would seek private sector care to rely on the public system for treatment. Although fees are charged based on ability to pay, more expensive modalities, such as residential treatment, are underwritten by tax dollars.

Fragmentation continues to exist across the agencies serving individuals with mental illnesses, serious emotional disturbances, mental retardation, or substance use disorders. Funding streams continue to be categorical, making it difficult to provide the flexibility needed to create choices among the services and supports that promote self-determination and person-centered planning, empowerment, recovery, and resilience for individuals receiving services.

Virginia's public services system has been affected by losses of other revenues previously dedicated to treatment for adult criminal justice (loss of SABRE funding) and juvenile justice (loss of Title IV-E funds) populations and by the upcoming closure of the Department of Juvenile Justice's Barrett Learning Center. The adult and juvenile justice systems are also experiencing reductions in funds that support their own treatment and other diversion activities. Juvenile Justice will soon be required to establish standards for community treatment, placing more demand on the public treatment system. Since CSBs try to serve these individuals, the loss of additional funding previously available from these systems further limits community treatment capacity.

The demand for various community services is relatively uncontrolled and fluctuates over time by locality in response to a wide variety of influences. These influences include the availability or non-availability of services from CSBs or other agencies, shifting demographic patterns (e.g., variable population growth and migration among regions) across Virginia, and decisions made by individuals or family members about when, where, and from whom to seek services. The local public mental health, mental retardation, and substance abuse services system has continued to increase in complexity during the past decade. CSBs are now serving more individuals with more severe disabilities. For example, the numbers of individuals with serious mental illnesses or serious emotional disturbances increased by 25.82 percent between FY 1997 and FY 2003. Services provided to individuals have increased in intensity or specialization. For example, the average units of service per individual for mental health case management increased from 16.87 hours per individual in FY 1997 to 19.03 hours in FY 2003, a 12.80 percent increase in intensity.

The Department asked the CSBs to complete a point-in-time automated database to document the specific service requirements of individuals on CSB waiting lists during the first three months of 2005. To be included in the database, an individual had to have sought a service from the CSB and been assessed by the CSB as needing that service. A summary of services needed, individual risk factors or special circumstances, and average service wait times by program area follow. Services are defined in Appendix C.

Numbers of Individuals on CSB Mental Health Services Waiting Lists by Service January – April 2005

Service	Adult	C&A	Service	Adult	C&A
Outpatient Services					
Psychiatric Services	1,310	702	Intensive SA Outpatient (MI/SA)	248	34
Medication Management	1,356	690	Intensive In-Home		387
Counseling and Psychotherapy	1,756	1,058	Case Management	952	756
Assertive Community Treatment	370				

Service	Adult	C&A	Service	Adult	C&A
Day Support Services					
Day Treatment/Partial Hospitalization	289		Supported Employment Group Model	157	19
Rehabilitation	567	8	Transitional or Supported Employment	439	79
Therapeutic Day Treatment		302	Alternative Day Support Arrangements	247	156
Sheltered Employment	183	24			
Residential Services					
Highly Intensive (MH)	122	24	Supervised	318	41
Highly Intensive (SA Detox)	127	5	Supportive	710	72
Intensive	176	28	Family Support	255	494
Early/Infant-Toddler Intervention					
Infant and Toddler Intervention		49			

Of the children and adolescents on waiting lists for CSB mental health services, 1,684 were identified by the CSBs as currently needing specific services, 65 were identified as needing specific services beginning the 2008-2010 biennium, and 54 were identified as needing specific services beginning in the 2010-2012 biennium. Of these children and adolescents, 236 were in a Comprehensive Services Act mandated population and 1,024 were in a non-mandated population.

Additionally, there are currently 134 individuals in state hospitals whose discharges have been delayed due to extraordinary barriers.

**Numbers of Individuals on CSB Mental Retardation Services Waiting Lists by Service
January – April 2005**

Service	MR	Service	MR
Outpatient Services			
Psychiatric Services	492	Intensive In-Home (MR/MI)	169
Medication Management	599	Assertive Community Treatment (MR/MI)	24
Behavior Management	631	Case Management	2,697
Day Support Services			
Rehabilitation (Center and Non-Center Based)	545	Supported Employment Individual Model	605
Sheltered Employment/Prevocational	564	Alternative Day Support Arrangements	751
Supported Employment – Group Model	533		
Residential Services			
Highly Intensive (ICF/MR or Other Specialized)	210	Supervised (Congregate)	800
Intensive (Congregate)	813	Supportive (Supported Living, In-Home,	2,187

Service	MR	Service	MR
		Personal Assistance, Companion Services, Respite)	
Early Intervention			
Infant and Toddler Intervention	156		
Other Services and Supports			
Nursing Services	194	Environmental Modifications	279
Assistive Technology	396	Personal Response System (PERS)	44
Therapeutic Consultation	375	Family Support Services	1,043

Of the individuals on waiting lists for CSB mental retardation services, 3,847 were identified by the CSBs as currently needing specific services, 733 were identified as needing specific services beginning the 2008-20010 biennium, and 363 were identified as needing specific services beginning in the 2010-2012 biennium. Of the children and adolescents on waiting lists for CSB mental retardation services, 321 were in a Comprehensive Services mandated population and 484 were in a non-mandated population.

Additionally, there are 162 individuals in training centers who, with their authorized representative or family member, have chosen to continue their training and habilitation in the community instead of a state training center.

**Numbers of Individuals on CSB Substance Abuse Services Waiting Lists by SA Service
January - April, 2003**

Service	Adult	Adol.	Service	Adult	Adol.
Outpatient Services					
Psychiatric Services	487	111	Intensive In-Home		69
Medication Management	416	81	Methadone Detox	26	0
Counseling and Psychotherapy	1,432	200	Opioid Replacement	144	0
Intensive SA Outpatient	1,196	120	Case Management	759	140
Assertive Community Treatment	18				
Day Support Services					
Day Treatment/Partial Hospitalization	154		Supported Employment Group Model	88	2
Rehabilitation	99	7	Transitional or Supported Employment	22	14
Therapeutic Day Treatment		32	Alternative Day Support Arrangements	256	5
Sheltered Employment	16	9			
Residential Services					
Highly Intensive	279	20	Supportive	120	13
Intensive	115	57	Family Support	215	

Service	Adult	Adol.	Service	Adult	Adol.
Supervised	120	13			
Early Intervention					
Early Intervention		23			

Of the adolescents on waiting lists for CSB substance abuse services, 46 were in a Comprehensive Services Act (CSA) mandated population and 258 were in the CSA non-mandated population.

Average Wait Times for CSB MH, MR, and SA Services: CSBs estimated the number of weeks individuals waited prior to their actual receipt of specific services. Average wait times across the CSBs for specific services follow.

Initial Assessment: Adults and children and adolescents waited over a month for initial assessments for mental health services and almost three weeks for initial assessments for mental retardation and substance abuse services.

Outpatient Services: Adults with mental illness waited just under eight weeks for psychiatric and medication services, almost 10 weeks for counseling and 26 weeks for assertive community treatment. Children and adolescents waited almost seven weeks for intensive in-home and just over 5 weeks for medication, psychiatric, and counseling services.

Adults with mental retardation waited almost 47 weeks and children and adolescents waited almost 31 weeks for behavior management services. Adults with mental retardation waited almost eight weeks for medication services and six weeks for psychiatric services. Children and adolescents waited almost four weeks for medication services and slightly longer than four weeks for psychiatric services.

Adults with substance use disorders waited almost 11 weeks for methadone detox and just under seven weeks for opioid replacement services, almost eight weeks for intensive outpatient, almost six weeks for medication services, just under seven weeks for psychiatric services, and almost five weeks for counseling. Adolescents waited almost six weeks for medication services, slightly longer than five weeks for psychiatric services, almost four weeks for counseling, just over three weeks for intensive outpatient services, and three weeks for methadone detox services.

Case Management: Adults with mental illnesses waited slightly longer than eight weeks and children and adolescents waited 3 weeks. Adults with mental retardation waited almost 13 weeks and children and adolescents waited almost 32 weeks. Adults with substance use disorders waited slightly longer than 4 weeks and adolescents waited just over two weeks.

Day Support Services: Adults with mental illnesses waited 22 weeks for supported employment, 21 weeks for sheltered employment, almost 17 weeks for rehabilitation, 13 weeks for alternative day support arrangements, just under nine weeks for transitional or supported employment, and two weeks for day treatment/partial hospitalization. Children and adolescents waited 12 weeks for alternative day support arrangements, eight weeks for rehabilitation, and six weeks for therapeutic day treatment.

Adults with mental retardation waited just under 68 weeks for rehabilitation, almost 48 weeks for sheltered employment, almost 42 weeks for alternative day support arrangements, almost 38 weeks for supported employment group model, and almost 18 weeks for transitional or supported employment services. Children and adolescents waited 83 weeks for rehabilitation, 27 weeks for alternative day support arrangements, almost 15

weeks for sheltered employment, just under 14 weeks for transitional or supported employment, and 10 weeks for supported employment group model.

Adults with substance use disorders waited seven weeks for transitional or supported employment, almost seven weeks for sheltered employment, six weeks for supported employment group model, and two weeks for rehabilitation.

Residential Services: Adults with mental illness waited 126 weeks for highly intensive, almost 58 weeks for intensive, just under 43 weeks for supervised, and almost 17 weeks for supportive residential services and 6 weeks for family support services. Children and adolescents waited 12 weeks for highly intensive residential, six weeks for family support, almost two weeks for supportive residential, and one week for intensive residential services.

Adults with mental retardation waited slightly longer than 115 weeks for intensive, almost 82 weeks for highly intensive, and almost 75 weeks for supervised and supportive residential services and almost nine weeks for family support services. Children and adolescents waited almost 237 weeks for supervised, 202 weeks for highly intensive and intensive, and just under 53 weeks for supportive residential services and almost three weeks for family support services.

Adults with substance use disorders waited almost 5 weeks for supportive, just under three weeks for intensive and supervised, and slightly longer than two weeks for highly intensive residential services and two weeks for family support services. Adolescents waited almost three weeks for intensive residential and family support services.

Early Intervention Services: Young children waited almost four weeks for infant and toddler intervention services. Children and adolescents waited just over three weeks for substance abuse early intervention services.

MR Waiver Services: Adults with mental retardation waited 87 weeks for personal response system (PERS) services, almost 74 weeks for nursing services, almost 48 weeks for therapeutic consultation, and slightly longer than 36 weeks for environmental modifications and assistive technology services. Children and adolescents waited slightly longer than 78 weeks for PERS services, 56 weeks for nursing services, almost 40 weeks for therapeutic consultation, just over 36 weeks for environmental modifications, and slightly longer than 32 weeks for assistive technology services.

Anticipated Changes in the Population Needing Mental Health, Mental Retardation, and Substance Abuse Services:

Changes in the population needing mental health, mental retardation, and substance abuse services over the next six years are likely to mirror those in the overall United States population. Community programs will increasingly serve an older population, many of whom may experience complications from a variety of physical illnesses. An increasing number of individuals will require CSB services and supports to enable them to reside in a nursing home or assisted living facility. Changes in the state's Medicaid benefit package also will be needed to better address the needs of medically fragile individuals who also have a mental illness, mental retardation, or substance use disorders. To avoid over reliance on state inpatient care for these individuals, it will be important to create more flexible Medicaid reimbursement mechanisms for community-based services that are appropriate for older individuals with mental illness.

With advances in medical and assistive technologies, individuals with severe or profound levels of mental retardation now live a nearly normal lifespan. As these individuals grow older, they are likely to develop other health problems such as Alzheimer's disease that will require specialized services and supports. Services must be designed to address the evolving needs of these individuals over time to provide continuity in their care and living environments. The Department and the services system must look at new models of community-based services as alternatives to training center placement for these individuals.

As Virginia's population ages, there will be increasing demand for specialized substance abuse services for older persons with substance use disorders. If abuse of alcohol and legal drugs among older Virginians were to continue at the same rate as their U.S. counterparts (17 percent), demand for specialized treatment services could be 1.5 times greater in 2030 because of population growth.

The current generation of parents of individuals with mental retardation are aging and many, due to infirmity or death, will soon be unable to care for their adult children with mental retardation. According to a national study of state services, the majority of these individuals reside with family members. The number of persons with MR living with caregivers aged 60 years and older in 2002 was estimated to be 16,903. Demand for alternative housing and structured support options will increase dramatically as the large cohort of baby boomer parents reach retirement age.

The service system's increasing ability to assess mental retardation and co-occurring mental or physical disabilities, including mental illness, autism, and severe physical disabilities, will challenge a system that is already deficient in addressing support and treatment needs of these groups. Greater numbers of children currently coming through Virginia's school systems are being identified as having autism, with and without a co-occurring condition of mental retardation. This increase reflects a national trend that some label an epidemic. A significant proportion of individuals seeking treatment for substance use disorders also suffer from some form of mental illness. Left undiagnosed and untreated, mental illness will certainly cripple the individual's effort to attain stability and remain drug or alcohol free. Yet, too few professionals are trained to address both disorders, and there is a dearth of psychiatric resources available to treatment programs for substance use disorders.

A review of 2002 National Household Survey on Drug Use and Health data suggests that the use of illicit substances (e.g., cocaine and heroin) and the non-medical use of prescription pain relievers and stimulants, particularly among youths and young adults, are increasing. Alcohol use has been increasing steadily since 1990, with youth under age 18 accounting for much of the increase. Adolescent use nearly doubled, from 2.2 million in 1990 to 4.1 million in 2000, with gender distribution about equal. Southwest Virginia continues to experience a significant increase in overdose deaths from methadone (a synthetic opiate) prescribed by rural physicians as an analgesic and lacks any significant capacity to effectively treat opiate addiction. Methamphetamine use is also becoming more prevalent, spreading from the western portion of the United States.

Implementation of Evidence-Based and Best Practices

Evidence-based practices (EBPs) are those interventions that integrate the best research evidence with the best clinical expertise and values focused on individuals receiving services (Institute of Medicine Report Crossing the Quality Chasm, 2001). Evidence-based practices emphasizing individual participation, choice, recovery, and self-determined outcomes have the potential to significantly improve the quality of life for individuals receiving services.

The 1999 *Surgeon General's Report on Mental Health* prompted increased attention among policy-makers and payers to the issues associated with implementation of evidence-based practices in mental health. The Surgeon General's Report underscored that, for the most part, the effective interventions that exist for many mental disorders are simply not available to the majority individuals who could benefit from them. There are several evidence-based practices for the treatment of serious mental illnesses in adults and serious emotional disturbance in youth. These include:

For adults with serious mental illness:

Co-Occurring Disorders: Integrated Dual Disorders Treatment
Illness Management and Recovery
Medication management Approaches in Psychiatry
Family Psychoeducation
Supported employment
Assertive community treatment (ACT)

For children and adolescents with emotional disturbance or substance use disorders:

Multi-systemic Therapy (MST)
Functional Family Therapy (FFT)
Motivational Enhancement Therapy (MET)
Cognitive Behavioral Therapy (CBT)
Integrated Community Treatment
Therapeutic Foster Care
Some prevention interventions.

In the area of substance abuse services, rapid advances in brain-imaging technology, pharmacology, and evaluation of counseling techniques and supports have radically altered approaches to treating substance use disorders in the last five years. Scientific evidence overwhelmingly supports addiction and dependence as diseases of the brain. Concurrently, pharmacological approaches to treating substance use disorders have expanded from methadone and antabuse to include buprenorphine, acamprosate calcium, and naltrexone. The use of specific counseling techniques, particularly Motivational Interviewing, has been widely studied and shown to be effective in helping persons with substance use disorders address characteristic denial and weak commitment to treatment. Finally, a greater understanding of the prevalence and impact of co-occurring disorders on the development and treatment of substance use disorders is demanding more attention to treatment models for those individuals with co-occurring mental illness and substance dependence.

Experts in the field of prevention have developed rigorous approaches to evaluate and identify prevention programs that are effective. These programs are recognized by state and federal mental health, substance abuse, education, and juvenile justice systems as evidence- or science-based programs.

In the area of mental retardation, challenging behaviors can adversely affect an individual's abilities and opportunities to participate fully in any aspect of community life. Positive Behavior Support (PBS) offers a comprehensive, science-based approach to behavior change that teaches people with challenging behaviors and the people who support them new skills for successful living in the community. PBS integrates behavioral technology with person-centered values and has been successful with children and adults who have mental retardation or other developmental disabilities.

Virginia has made significant progress in implementing selected evidence-based practices. For example, Programs of Assertive Community Treatment (PACT) have been developed in 15 CSB areas, and Multi-Systemic Therapy for adolescents is offered at several other CSBs. Most individuals have access to "new generation" medications, whether in CSB or state facility programs. Outcome data from the PACT initiatives have shown dramatic reductions in state hospital usage, increased stability in living situations for individuals, and reduced involvement with criminal justice agencies. The Department also supports family psycho-education through its contracts with family support groups and the Southwest Virginia Behavioral Health Board. Most individuals receiving services in the public mental health system, however, do not have consistent access to evidence-based services.

In FY 2005, the Department was awarded a three-year, \$300,000 total, Real Choice Systems Change Grant from the Centers for Medicare and Medicaid Services (CMS) to support infrastructure development of the evidence-based practices for adults with serious mental illnesses. This grant is intended to align Virginia's existing community mental health Medicaid Rehabilitative Services with the evidence-based practices of assertive community treatment (ACT), illness management and recovery (IM&R), and supported employment (SE) and to maximize opportunities for peer specialists and peer-operated programs. Grant activities will follow a proven path to adopting and implementing evidence-based practices, consistent with Virginia's successful experience in implementing PACT teams. This will include a focus on consensus and partnership building with multiple stakeholders and constituencies to develop Virginia-specific models of IM&R and SE; regulatory analysis and clear articulation of Department, DMAS, and DRS funding streams that support PACT, IM&R, and SE services; provider training, consultation, and technical assistance; evaluation of implementation, measurements of fidelity to the models and individual outcomes; and plans to expand, sustain, and maintain a high level of quality services.

Virginia state agencies, local service providers, and individuals with mental retardation and their family members received extensive training in the late 1980s and early 1990s from the National Research and Training Center for Positive Behavioral Support at the University of Oregon. This training in positive behavioral supports (PBS) was replicated around the state in several communities during the mid 1990s. In October 2002, the Partnership for People with Disabilities received a grant from the Virginia Board for People with Disabilities to promote the utilization of PBS across the lifespan of Virginians with disabilities and challenging behaviors. Project goals include obtaining consensus from licensing, certification, and funding agencies for PBS utilization for individuals with developmental and other disabilities and developing a certification process and mechanism for intensive training for PBS practitioners. While this has been a positive initiative, resource constraints continue to limit the availability and consistency of this time-intensive training, and Behavioral Consultation under the MR Waiver is currently limited to a very small number of providers (approximately 25), few of whom have PBS training. The Department is actively involved in this activity.

Several initiatives are helping to increase the use of substance abuse evidence-based practices in CSBs and their contract agencies. First, an extensive program of technology transfer is underway, as described in Section F, Human Resources Management and Development. In addition, guidance bulletins are being developed and distributed to the CSBs that identify "best practices" in specific areas of clinical practice. Regularly scheduled technical support visits to CSBs provide assistance in clinical issues, including identifying clinical practice models and assisting with evaluation design. The Department also funds 12 science-based prevention programs for families, including services for new parents, Head Start children and their parents, and families with children and adolescents. Program directors are working closely with program developers and university faculty to evaluate the programs. Thus far, program evaluation data indicate that children gained in their awareness of drug harm and increased their levels of cooperation and social skills. Evaluation results for parents show fewer inappropriate parental expectations and increased overall parenting and monitoring skills. Evaluation of the families showed an increase in communication skills and family interaction.

The Department, CSBs, individuals receiving services and families, and others have recognized the importance of working together to develop, disseminate, and support evidence-based service models and uniform clinical practices that will promote positive individual outcomes. Such efforts would include defining the extent and quality of "evidence" necessary for services and interventions to qualify as evidence-based practices (e.g., multiple randomized clinical trials, quasi-experimental research, qualitative evidence, etc). Adoption of uniform clinical practices by the CSBs would also help promote consistency across services throughout the state and permit clear identification of service system gaps where they exist. While still allowing

for local variation and innovation, a core set of evidence-based clinical practices for community services across the state also would help ensure informed individual choices and ease of movement from one service area to another. The Department must increase its focus on adopting evidence-based practices for persons with mental illness, mental retardation, or substance use disorders to effectively achieve its mission.

Advances in communication technology greatly enhance the dissemination and transfer of information to practitioners and can make the most current research and other information readily accessible to most practitioners, allowing them to integrate this information into their daily practice. Opportunities exist to strengthen Virginia's services system through this technology.

To effectively adopt evidence-based practices, several ingredients must be in place, including

- Commitment of leadership at each level (state, local, program),
- Education and skill building for practitioners,
- Supportive administrative practices,
- Incentives and rewards,
- Feedback mechanisms (e.g., measurement of outcomes), and
- Stable long-term financial support for EBPs.

Additional resources will be needed to raise awareness of evidence-based practices, enhance competency among providers, and develop and sustain programs and services.

State Hospital and Training Center Services

State hospitals and training centers are critical components in the continuum of care for individuals with mental illness, mental retardation, or substance use disorders. State hospitals provide a variety of clinical services that are structured to best meet each individual's needs and include: psychiatric assessment and stabilization; medication management; psycho-social rehabilitation programming; psychiatric and rehabilitative therapies; and, in collaboration with the CSBs, discharge planning. Services are further specialized by the age groups served at a facility and incorporate cultural competency. These facilities provide services and supports to persons with serious mental illnesses and serious emotional disturbances who are in crisis, who present with acute or complex conditions, or both, and who require the highly intensive and structured environments of care only available in an inpatient setting. Services provided by state hospitals focus on psychiatric stabilization and development of skills needed for successful community living. These services enable individuals to develop skills and supports needed for success and satisfaction in specific environments and enhance other fundamental life skills, such as developing trusting relationships, increasing hope, motivation, and confidence, and making informed choices.

State training centers provide services and supports to persons with mental retardation who require the highly intensive and structured environments of care. Training center services include medical and psychiatric assessment, healthcare, medical stabilization, habilitation, and development of skills needed for successful community living. Although long-term care has been their main function, training centers also provide short-term respite care and emergency care. All training centers meet federal requirements for designation as Intermediate Care Facilities (ICF/MR) and one, CVTC, also operates skilled nursing and acute care beds. Training center services also address the needs of individuals with mental retardation and co-occurring mental illness or challenging behaviors and persons with co-occurring severe developmental disabilities and medical complexity.

The Department must ensure that each state facility has sufficient numbers of trained personnel across the entire spectrum of clinical and direct care positions to provide quality care and treatment. Sufficient staffing is absolutely necessary in order to provide appropriate assessment, treatment, rehabilitation, training, and habilitation for individuals in accordance with clinical standards and create and maintain a safe treatment environment.

The Civil Rights of Institutionalized Persons Act (CRIPA) established broad authority for the United States Department of Justice (DOJ) to investigate matters of infringement on the constitutional rights of patients cared for in state facilities. From May 1990 to August 2003, the DOJ investigated conditions at four state hospitals, Eastern State Hospital (ESH), Central State Hospital (CSH), Western State Hospital (WSH), and Northern Virginia Mental Health Institute (NVMHI), and at the Northern Virginia Training Center (NVTC). Site visits by DOJ at these facilities determined that these facilities were significantly deficient in providing constitutionally adequate, appropriate psychiatric assessment and treatment, and adequate medical care. A core problem at each facility was inadequate levels of trained and qualified staff required to provide the services needed by individuals.

As a result of findings from several site visits, the Commonwealth entered into agreements with the DOJ that required Virginia to bring each of these state facilities into compliance with certain staffing levels believed to be necessary to render constitutionally adequate mental health care. During the litigation by the DOJ, the General Assembly appropriated funding to create additional staff positions and implement other improvements at the five state facilities under DOJ investigation. The Commonwealth has been successful in meeting the requirements in each facility's settlement agreement, with four of the agreements filed with the federal court, and the fifth closed by correspondence from DOJ.

Although the Department has made significant strides in improving state facility staffing levels, there still are areas where the level of care does not meet the levels set forth in the DOJ settlement agreements. Several state facilities have increased their staffing ratios somewhat by reducing beds through such community initiatives as the Discharge Assistance Project (DAP), Programs of Assertive Community Treatment (PACT), the Region IV Acute Care Pilot Project, Regional Admission Committees (RACs), and Medicaid Mental Retardation Home and Community-Based Waiver services. However, such strategies have been hindered by state budget shortfalls that required state facilities and CSBs to reduce their operating budgets. State facilities experiencing staffing issues include: Southern Virginia Mental Health Institute (SVMHI), Southwestern Virginia Mental Health Institute (SWVMHI), the Commonwealth Center for Children and Adolescents (CCCA). Additionally, Central Virginia Training Center (CVTC), Southeastern Virginia Training Center (SEVTC), Southside Virginia Training Center (SVTC), and Southwestern Virginia Training Center (SWVTC) continue to experience specific staffing issues in recruiting and retaining nurses and direct care staff, psychiatrists and primary care physicians, psychologists, primary care physicians, dieticians, occupational and physical therapists, rehabilitation engineers (for specialized wheelchairs), speech pathologists, and audiologists.

The report of the Mental Retardation Special Populations Workgroup cites two very distinct populations being served in the training centers: individuals with mild to moderate levels of mental retardation with co-occurring mental illness and challenging behaviors and individuals with severe and profound levels of mental retardation with very compromised and complex physical and medical conditions. All five training centers are experiencing greater demands to serve persons who have mild or moderate mental retardation but also have challenging behaviors that require significant behavioral interventions. In order to meet those needs and to provide community consultations to divert potential admissions, the training centers need to establish behavioral management teams, which require smaller caseloads and additional psychologists. A large proportion of individuals served by training centers is non-ambulatory

(requiring specialized wheelchairs) or needs significant staff assistance to walk. Many have multiple, complex medical conditions such as seizures, scoliosis, gastrointestinal problems, hearing or visual deficits, or both, or speech impairments. These medical needs are projected to increase in the years to come because the training center population is aging. All of these conditions make appropriate staffing critical to the well being of these individuals.

All state facilities are experiencing increased pharmacy costs. Prescription drugs are the fastest growing segment in health care expenses in the United States. State facilities are already serving proportionately greater numbers of individuals with significant and complex psychiatric and medical conditions that require specialized pharmacologic interventions. In an effort to contain spiraling drug costs, the Department plans to develop a Medication Management System in each state facility as part of an agency electronic health record. This system should improve linkages between critical databases, allowing facilities to improve individual care and clinical outcomes and to promote safe, effective, and efficient pharmacy services.

Implementation of a new Medicare drug benefit, Medicare Part D, is scheduled to go into effect on January 1, 2006. Under this new benefit, drug coverage will be offered through private sector prescription drug plans and Medicare advantage plans. While the Part D program will be voluntary for many Medicare beneficiaries, it will be mandatory for low-income individuals who are concurrently eligible for both Medicaid and Medicare. Billing for Medicare Part D will originate within the state facility pharmacy departments. This will necessitate pharmacy system software upgrades and intense staff training and education to support Medicare Part D implementation and reimbursement.

All state facilities also are experiencing increases in gas and fuel costs for which funds are not currently budgeted. Several facilities also have equipment and van replacement needs. Additional support staff positions also are needed at these facilities to 'free up' clinical and direct care staff to focus on individual treatment and habilitation. In a time of nursing shortages, such tasks are not only a waste of an essential clinical resource, but they also negatively impact recruitment and retention.

Prevention Service Priorities

Substance Abuse Prevention Services: Prevention services include activities that involve people, families, communities, and systems working together to promote their strengths and potentials. Prevention is aimed at substantially reducing the incidence of alcohol, tobacco, and other drug use and abuse, with a focus on the enhancement of protective factors and the reduction of risk factors.

Effective prevention services reduce the number of new cases of substance use disorders by reducing risk factors and increasing protective factors. Risk factors may be biological, psychological, social, or environmental and can be present in individuals, families, schools, and the community. Prevention researchers have determined that when a child experiences a higher number of risk factors, such as poor school achievement, parents with poor family management skills, and neighborhoods where drug use is tolerated, the child is more likely to experiment and use alcohol, tobacco, and other drugs. Protective factors such as social and resistance skills, good family and school bonds, and the capacity to succeed in school and in social activities can reduce the impact of present risk factors. In order to promote greater success and minimize risk for substance use and abuse for children in a community, human service providers, schools, law enforcement organizations, faith and business communities, and parents and youth work together in prevention planning coalitions to create and strengthen protective factors while reducing risk factors in all domains of individuals, homes, schools, and the community.

The Department oversees and manages substance abuse prevention services delivered through the CSBs. Currently, all community-based prevention services are funded with the SAPT Performance Partnership Grant and meet federal regulations that direct their use. The Department adopted a community-based prevention planning process in 1995. Through this process, CSBs work with representatives of human service agencies, education organizations, and local governments to conduct needs and resource assessments, identify service gaps and unserved populations, and plan, implement, and evaluate prevention programs that address the identified risk factors. CSBs reported that prevention planning groups identified the following as the most significant risk factors: availability of drugs, family management problems, and early initiation of problem behavior.

Selection and prioritization of these risk factors is supported by the FY 2003 statewide youth survey. This survey found that 43 percent of the surveyed youth said alcohol, cigarettes, and drugs were easy to obtain. The average age of first use of tobacco products for Virginia youth was 12.51 years old, as compared to 12.09 in the 2000 survey. The average age of first use of alcohol was 13.87 years, up from 12.62 years in the 2000 survey, with 14.37 percent of the surveyed youth reporting that they were drinking regularly, a decrease from the 16.2 percent in the 2000 survey. The increase in the age of first use and the decrease in the percentage of youth drinking regularly may reflect a positive trend that will continue in the 2005 youth survey.

Populations identified as in need of services were school age youth and families. The Prevention and Promotion Advisory Council to the State Board has also identified the need to focus on prevention services for the family.

Suicide Prevention: The Department was designated by the General Assembly as the Commonwealth's lead agency for suicide prevention across the life span in 2005. Other agencies involved in this effort include the Department of Health, the Department for the Aging, the Department of Juvenile Justice and the Department of Corrections. Together, the agencies work to promote awareness and provide training to individuals and groups throughout Virginia aimed at reducing suicide across the life span. In collaboration with other agencies, the Department prepared a report titled *Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia*. Broad aims of the plan include: prevention of death from suicide, reduction of the occurrence of other self-harmful acts, increased risk recognition and access to care, promotion of the awareness of suicide, and reduction of the stigma associated with suicide. The plan focuses on leadership and infrastructure development, awareness, and intervention. Since 2000, 40,000 persons have been trained. The Department is also a member the Interagency Suicide Advisory Committee and the Virginia Suicide Prevention Council. These groups provide advice on planned suicide prevention activities and strategies.

Prevention of Youth Access to Tobacco Products: The Synar Amendment to the federal Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act requires that states conduct annual inspections of randomly selected tobacco retail outlets to determine how likely it is that underage youth are able to purchase tobacco products. The states must conduct compliance inspections of tobacco vendors as a condition for receipt of Substance Abuse Prevention and Treatment (SAPT) Block Grant funds, which support community substance abuse treatment and prevention services and total approximately \$42 million. The rate of noncompliance must not exceed a previously agreed upon target rate, or 20 percent noncompliance by FFY 2003. The current rate of 13 percent is well below the 20 percent target.

Disaster and Terrorism Preparedness and Recovery

Services System Preparedness: Virginia is the fifth most likely place for a disaster to occur in the United States. The continuing threat of terrorism, such as that which occurred September 11, 2001, the serial sniper attacks, and natural disasters such as Hurricane Isabel, make it clear

that the Virginia behavioral health system must be ready to respond. Virginia's first-hand experiences with disaster response have unequivocally confirmed that a rapid, efficient behavioral health response does assist individuals and communities in the recovery process. Following the attack on the Pentagon, Virginia initiated a crisis-counseling program, the Community Resilience Project, which was administered by the Department and delivered by the Northern Virginia CSBs. The project remained in full operation for 30 months and resulted in 683,000 crisis contacts and the distribution of more than 1.4 million pieces of educational literature to assist in coping and recovery. Similar crisis programs following Hurricane Isabel and other major events have supported countless Virginians. In the aftermath of these highly effective and successful behavioral health response initiatives, plans currently under development and revision in localities throughout Virginia, as well as at the state level, all include behavioral health as a critical and vital component in all aspects of emergency mitigation, preparedness, response, and recovery.

Central Office Infrastructure: The Department supports one full time staff position in the central office devoted solely to disaster and terrorism planning, preparedness, and response activities. This individual has worked to strengthen vital public-private partnerships needed to effect an appropriate emergency response; developed and implemented training curricula for state facility, CSB, and public sector staff on emergency mental health response interventions; and established protocol for the development of mutual aid agreements among and between state facilities, community hospitals, and other health care organizations in Virginia. Additional key activities have included convening a Facility Preparedness Workgroup, consisting of state facility staff, to plan, prepare, and coordinate the Department's facility assets; serving as chair of the Terrorism and Disaster Behavioral Health Advisory Council, (TADBHAC), a group of experts convened by the Governor to guide and inform the Commonwealth on behavioral health and disaster preparedness and response best practices; and training CSB and state facility staff in the delivery of services and supports to individuals served in Family Assistance Centers.

During a disaster situation, additional emergency response capacity in the central office is needed to perform necessary preparedness, immediate response, and coordination activities with other state agencies, state facilities, and CSBs, as necessary. This includes coordinating and preparing federal grants to secure federal emergency response funding. Also, augmented public information functions in the aftermath of a terrorism event are of critical importance, given the clear and pervasive mental health implications attached to such events. Accurate, timely, and instructive information must be available to the public to minimize fear and anxiety.

State Facility Preparedness: JCAHO emergency management standards require hospitals and long term care facilities to engage in cooperative planning with other health care organizations (e.g. other hospitals providing services to a contiguous geographic area) to facilitate the timely sharing of information, resources, and assets in an emergency response. State facilities have engaged in local and statewide planning processes that have resulted in identification and pooling of assets and regional evacuation planning. While state facilities are poised to assist in any community emergency response, Department policy requires that facility resources and assets first be made available to respond to the needs of individuals receiving state facility services and staff. Several state facilities have partnered with regional emergency planning efforts to increase regional hospital surge and response capability. An analysis of state facility assets conducted by Facility Preparedness Work Group determined that significant additional funding is needed to increase emergency generator capacity at those facilities.

Community Services Board Preparedness: CSBs have developed All-Hazards Disaster Response Plans that include attention to each stage of an emergency event. These plans will be used to assure CSBs are prepared to respond to all types of disasters that may occur in their service areas. Additionally, CSBs have undertaken efforts to develop collaborative relationships with their local public health departments and emergency management agencies. Through the

availability of Virginia Department of Health funds, CSBs have participated in regional training forums on disaster response and behavioral health interventions. Emphasis for the upcoming year will include additional disaster response training and development of memorandums of understanding with local response partners.

Goals, Objectives, and Action Steps

Goal 7: Work collaboratively on an ongoing basis with the Secretary of Health and Human Resources (HHR), the Community Integration Oversight Advisory Committee, the Community Integration Implementation Team, and all State agencies involved in implementing recommendations in the Olmstead Task Force Report.

Objectives:

- 1. Promote the concepts of treatment in the most integrated settings and individual and family choice that are central to the Olmstead Decision.***

Action Steps:

- Monitor the appropriate movement of discharge ready individuals from state facility to community-based services.
- Provide reports on the status of discharge ready individuals to the State Human Rights Committee, local human rights committees, and human rights advocates.
- Monitor Department and system's efforts toward maintaining youth in the community following their transition to adult services.

- 2. Prepare legislative proposals and budget requests to implement the Olmstead Task Force recommendations for which the Department has primary responsibility.***

Action Steps:

- Using the time frames and recommendations as set forth in the Report, and working with all appropriate stakeholders, prepare legislative and budget proposals for consideration by HHR, DPB, and the Governor.
- Work with other state agencies as appropriate to collaborate in the preparation of legislative and biennium budget proposals.

- 3. Participate with the Community Integration Oversight Advisory Committee and the Community Integration Implementation Team in planning and implementing the Commonwealth's response to the U.S. Supreme Court Olmstead decision.***

Action Steps:

- Prepare information, analyses, and reports as requested.
- Contribute to the annual reports submitted to the Committee.

Goal 8: Promote the establishment of an integrated system of service delivery that is responsive to the mental health, mental retardation, and substance abuse needs of children and adolescents and their families.

Objectives:

- 1. Take steps to implement the continuum of mental health, mental retardation, and substance abuse services for children and adolescents.***

Action Steps:

- Implement evidence-based initiatives that expand systems of care in selected localities.

- b. Develop new and expand existing child and adolescent services necessary to fill gaps and build community capacity.
- c. Develop and implement community services for youth who are transitioning from children's services to young adult (ages 17-21) services.
- d. Establish fellowships and expand training and education opportunities to increase the numbers of child psychiatrists, child psychologists, and other difficult-to-recruit clinicians practicing in the Commonwealth.
- e. Provide ongoing behavioral health care training to child and adolescent behavioral health services providers and health care professionals such as pediatricians, family practitioners and primary care physicians.

2. *Continue to work to improve access by children, adolescents, and their families to mental health, mental retardation, and substance abuse services.*

Action Steps:

- a. Continue to support the efforts of the workgroup established by the Department to identify service needs and update the integrated policy and plan required by Item 330-F of the 2004 Appropriation Act.
- b. Provide leadership policy development in coordinating and planning for children with behavioral health needs with state agencies and for assisting local agencies to maximize resources for children's behavioral health services.
- c. Conduct a detailed analysis of the needs of medically fragile children with mental retardation.
- d. Build a statewide family support coalition to link existing family support organizations and groups.
- e. Support the activities of the state advisory committee for child and family services to the Department.
- f. Establish an interactive web site that can serve as a resource for parents and youth.

Goal 9: Promote the development of a comprehensive array of specialized prevention and treatment services and supports for elderly persons with mental and substance use disorders.

Objectives:

1. *Develop a comprehensive, community-based continuum of mental health, mental retardation, and substance abuse services for elderly Virginians.*

Action Steps:

- a. Work with CSBs, community providers of aging services, and community organizations to raise their awareness of the mental health, mental retardation, and substance abuse service needs of elderly Virginians.
- b. Provide technical assistance and training on service models that respond to the mental health, mental retardation, and substance abuse service needs of elderly Virginians.
- c. Quantify the increase in geriatric services that will be needed at each level in the continuum of care in response to the rapidly growing geriatric population.
- d. Work with the CSBs to establish a dedicated capacity in each CSB for responding to the services and support needs of elderly individuals.
- e. Develop a directory of psycho-geriatric services available in Virginia, organized by region, which describes available services and supports, entitlements, and how to access services.
- f. Explore potential financial resources for the development of individual-centered, family-focused, community-based services for elderly individuals that reflect best practices.

- g. Explore service models that would assist community nursing home and assisted living facility operators to effectively manage defined behaviors such as wandering and aggression that routinely result in expulsion from nursing homes and assisted living facilities.
- h. Explore the feasibility of implementing a gero-psychiatric pilot program or programs that would test and monitor outcome measures on a limited scale and allow for comparative analyses among various residential models, such as a nursing home with a dedicated wing or a separate residential facility.
- i. Work with the Department of Medical Assistance Services to establish a support model for elderly individuals who are receiving MR Waiver services.
- j. Coordinate with the Department for the Aging on the newly awarded three year Aging and Disability Resource Center grant creating nine “no wrong door” Decentralized Resource Centers.

Goal 10: Enhance Virginia’s capacity to intervene and divert individuals with mental illnesses and substance use disorders from the criminal justice system and to provide, using a community-focused program model, mental health and substance abuse evaluation and treatment services to individuals involved with the criminal justice system.

Objectives:

1. ***Develop an appropriate continuum of jail and community-based mental health and substance abuse services for individuals involved with the criminal justice system, using the recommendations from the multi-agency Forensic Special Populations Work Group as a basis for implementing changes to the current system of service delivery.***

Action Steps:

- a. Expand the number of jail-based mental health and substance abuse teams, improve access to medications, and develop other appropriate community diversion and post-release services.
- b. Improve and streamline the process of managing insanity acquitees who have been conditionally released.
- c. Enhance the capacity of CSBs to provide restoration to competency services in jails and community settings.

2. ***Implement, to the extent possible, national and state service models that represent best practices in areas such as crisis teams, assessments and diagnostic services, early identification procedures, treatment services, pre-release planning, assertive case management, post-release services, and drug courts.***

Action Steps:

- a. Incorporate national and state service models into long-range interagency planning activities.
- b. Provide training and technical assistance to criminal justice and mental health, mental retardation, and substance abuse services staff on national and state service models.
- c. Identify, and where appropriate, implement national and state service models that represent best practices across the Commonwealth.

3. ***Strengthen state and local collaboration necessary to provide an effective continuum of care for adult and youth offenders with mental health and substance abuse service needs.***

Action Steps:

- a. Continue to collaborate with the Departments of Criminal Justice Services (DCJS) Juvenile Justice (DJJ), and Corrections (DOC) in ongoing strategic planning, policy, and service development efforts.
- b. Expand the number of communities that have collaborative mental health and juvenile justice projects.
- c. Provide technical assistance to CSBs, jail and detention centers, sheriffs, and courts in the development of local interagency memoranda of agreement that clarify goals, define responsibilities, and outline specific activities and tasks, including procedures for accessing treatment in jails and detention centers and identifying case managers responsible for coordinating continuity of care across the systems.
- d. Monitor the status of memoranda of agreement between criminal justice and treatment agencies.
- e. Enhance the delivery of mental health services to incarcerated individuals to reduce demand for secure forensic treatment and to prevent re-hospitalization of individuals returned to incarceration following inpatient evaluation and treatment.
- f. Encourage participation of CSBs on local drug court planning and implementation committees.
- g. Provide training in mental illness and substance use disorders to criminal justice professionals and in criminal justice issues to mental health and substance abuse professionals.
- h. Implement interagency initiatives as resources become available.

4. *Provide timely forensic evaluation and treatment services in the most appropriate settings that meet but do not exceed the level of intervention needed to provide necessary treatment and maintain public safety.*

Action Steps:

- a. Continue to work with CSBs and private providers to expand their capacity to provide forensic evaluation services in the community.
- b. Continue to provide training and technical assistance to CSBs to enhance their management of insanity acquittees who have been conditionally released.
- c. Support CSB efforts to develop community placement alternatives for individuals found NGRI that provide a higher level of support and services access, thereby decreasing the need for prolonged and more restrictive hospitalization.
- d. Continue to explore resources for CSBs to provide community-based restoration to competency to stand trial services to the courts for nonviolent offenders not needing state hospital treatment.
- e. Establish sub-acute residential programs for individuals receiving forensic treatment in state facilities who no longer need an inpatient level of services.
- f. Continue to streamline and improve the Department's Forensic Review Panel privilege-granting process for state facility forensic patients who meet certain criteria.

5. *Develop new and maintain and expand existing treatment opportunities in communities and institutional settings for individuals with substance use disorders who are involved with criminal justice agencies.*

Action Steps:

- a. Pursue grant opportunities for delivery of services to offender populations.
- b. Continue to provide technical assistance to CSB services provided in jails and detention centers to adults and juveniles.
- c. Seek state funding for innovative programs aimed at jail diversion and improvement of services in local correctional facilities.

Goal 11: Provide individualized treatment services in a secure environment to individuals civilly committed to the Department as sexually violent predators.

Objectives:

- 1. Provide each SVP program resident with access to meaningful and individualized sex offender treatment.***

Action Steps:

- Use Departmental experts to assist in the design and development of treatment approaches, protocols, and practices for individuals who are civilly committed as sexual violent predators with co-occurring psychiatric or developmental disabilities.
- Continue to offer treatment programs in times and frequencies that are consistent with relevant clinical Departmental Instructions.
- Provide each resident with access to group and individual therapy, as appropriate.

- 2. Provide each SVP program resident appropriate access to psychosocial rehabilitation and work activity.***

Action Steps:

- Use national guidelines for rehabilitation, work, and recreation activities to inform program policies, procedures and activity plans.
- Use Departmental rehabilitation experts to assist in the design and development of appropriate work and recreation activities.

- 3. Offer each SVP program resident the maximum opportunity to develop the self-control necessary for returning to the community.***

Action Steps:

- Provide each resident with access to therapeutic methods designed to reduce interest in abusive sexual themes.
- Provide each resident with access to therapeutic methods designed to reduce impulsive sexual response to abusive sexual themes.
- Provide each resident with access to therapeutic methods designed to increase knowledge of, interest in, and sexual attraction to appropriate sexual themes.

- 4. Construct a new Center for Behavioral Rehabilitation in a permanent location.***

Action Steps:

- Develop community support for the placement of the new SVP facility.

Goal 12: Improve the quality and appropriateness of support and treatment for persons with a diagnosis of co-occurring mental retardation and mental illness.

Objectives:

- 1. Provide outreach and education to families and individuals receiving services about co-occurring mental retardation and mental illness.***

Action Steps:

- Develop educational materials that address various signs and symptoms associated with a person who may have co-occurring diagnoses of MR/MI.
- Encourage CSBs to assign staff with specific responsibility for helping individuals and families negotiate the entire set of services available to persons with co-occurring MR/MI diagnoses.
- Provide opportunities for the families and individuals receiving services to receive education about co-occurring MR/MI and actively participate in treatment planning

when an individual is beginning to show signs of decompensation, through the crisis period, and during transition back to the community.

- d. Improve the community-based system of supports by expanding the number of staff trained in positive behavioral supports.

2. *Promote and reinforce collaboration and joint responsibility in services provision, coordination, and oversight.*

Action Steps:

- a. Work with the CSBs and state facilities to develop formal memoranda of agreement that specify regional models for service delivery, community-based focus, involvement of all major system partners, specified tasks and responsibilities for all parties, and services based upon individual needs and supports rather than disabilities.
- b. Continue to provide administrative support at the state and CSB level for the activities of the MI/MR Steering Committee and the Regional MR/MI Workgroups.
- c. Improve the efficacy and usefulness of data collected for individuals with MR/MI, including the services and supports they receive, the environments in which services and supports are provided, and the manner in which services are reimbursed.

3. *Expand specialized community services and supports for individuals with a diagnosis of co-occurring mental retardation and mental illness.*

Action Steps:

- a. Develop a uniform set of standards for assessment and treatment programs for persons with co-occurring diagnoses of MR/MI that are based upon levels of support needed and encompass the entire "circle of need."
- b. Encourage CSBs to review current case management services and develop a system of intensive case management services that would better address the needs of individuals with co-occurring diagnoses of MR/MI.
- c. Collaborate with CSBs and state and local housing agencies to explore potential resources to support the development of a fuller range of residential alternatives for individuals with co-occurring diagnoses of MR/MI.
- d. Seek funding to develop a full range of specialized community outpatient services and supports, partial hospitalization, mobile crisis teams, PACT services, and residential and day or vocational services for persons with co-occurring diagnoses of MR/MI.
- e. Work with the Department of Medical Assistance Services to review the current MR Waiver consultative model and consider a more direct, hands-on service delivery approach for behavior specialists and establish clinical skills criteria for new behavior consultation contracts for serving individuals with co-occurring diagnoses of MR/MI.
- f. Establish an approval process for expanding the number of behavioral consultants to address the significant resource shortage for service providers and create sufficient expertise in the field.

4. *Develop and implement best practice service models in Virginia for persons with a diagnosis of mental retardation and co-occurring mental illness.*

Action Steps:

- a. Provide joint training for state facility and community administrators, clinicians, and direct care workers aimed at identifying and appropriately responding to the needs of individuals with co-occurring diagnoses of MR/MI, clarifying service responsibilities, and reconciling differences in language, philosophy, and expected outcomes between mental health and mental retardation services providers.

- b. Provide technical assistance and training to state facilities and community public and private providers on steps necessary to implement best practices for serving individuals with co-occurring diagnoses of MR/MI.
- c. Develop a plan, in collaboration with state facility and public and private community mental health and mental retardation services providers, to implement best practices in community and state facility settings.

5. *Provide training for psychiatrists, family practitioners, clinical psychologists, nurse practitioners, physician's assistants, and other clinical staff on psychiatric issues for persons with co-occurring diagnoses of MR and MI.*

Action Steps:

- a. Arrange for national experts to conduct training sessions for Virginia practitioners.

Goal 13: Provide appropriate assessments, interventions, and specifically designed programming to persons with co-occurring diagnoses of mental illnesses and substance use disorders.

Objectives:

1. *Improve the level of consultation, collaboration, and integration among providers of mental health and substance abuse services around policy, funding, staffing, and programming issues.*

Action Steps:

- a. As required by the COSIG grant, establish and provide staff support to an advisory committee on co-occurring disorders comprised of Department and CSB mental health and substance abuse staff and Mental Health Planning Council, Substance Abuse Services Council, advocacy group, and other representatives.
- b. Provide support to the activities of the committee and necessary workgroups.
- c. Work with the committee to produce recommendations for policies, funding, data collection, program development, service delivery, training, and staffing.
- d. Work with the committee to make policy, regulatory, and funding recommendations.

2. *As required by the COSIG grant, enhance the ability of CSBs to provide specifically designed services for individuals with co-occurring diagnoses of mental illnesses and substance use disorders.*

Action Steps:

- a. Conduct a major statewide technology transfer activity to promote knowledge and skill among administrators, clinicians, and gatekeepers regarding screening and assessment, case management, program design and treatment planning, funding, and data collection.
- b. Establish one center of excellence that will participate in ongoing evaluation of clinical outcomes and serve as consultants to providers implementing evidence-based practices for treating persons with co-occurring disorders.

3. *As required by the COSIG grant, establish uniform diagnostic criteria for identifying persons with co-occurring mental illnesses and substance use disorders.*

Action Steps:

- a. Identify or develop uniform diagnostic criteria to identify persons with co-occurring diagnoses of mental illness and substance use disorders and provide ongoing training, consultation, and technical support for effective knowledge transfer.

4. *Improve access to housing and case management for persons with co-occurring diagnoses of mental illnesses and substance use disorders.*

Action Steps:

- a. Design and implement a pilot integrated service model, including case management, with an evaluation component and provide ongoing training, consultation, and technical support for effective knowledge transfer.
- b. Explore use of traditional housing resources and nontraditional resources, such as self-governed residences, for persons recovering from co-occurring disorders.

Goal 14: Ensure quality and continuity of care for people who are deaf, hard of hearing, late deafened, or deafblind and are in need of mental health, mental retardation, or substance abuse services.**Objectives:**

1. ***Address the identified need for additional resources to meet the service demand of the people who are deaf, hard of hearing, late deafened or deafblind.***

Action Steps:

- a. Implement strategies to provide additional funding for the existing six regional programs, as supported by the Advisory Council, to be able to provide the intensive services required by this population.
- b. Implement strategies to expand statewide services to encompass regions that are currently underserved or not receiving services through the addition of regional coordinators or case managers as dictated by need.
- c. Explore with the Advisory Council the need for program enhancements and development of residential services to meet the needs of persons who are deaf, hard of hearing, late deafened, or deafblind.

2. ***Provide resources and interagency collaboration response to meet the needs of persons who are deaf, hard of hearing, late deafened, or deafblind in receiving mental health, mental retardation, or substance abuse services.***

Action Steps:

- a. Explore and implement strategies to expand statewide interagency and regional interagency coordination and collaboration.
- b. Explore strategies to expand the activities of the State Coordinator's position.
- c. Explore strategies to expand the interpreter reimbursement fund.

3. ***Strengthen existing policies and guidelines at state facilities and CSBs to promote access for persons who are deaf, hard of hearing, late deafened, or deafblind.***

Action Steps:

- a. Provide technical assistance and guidance on appropriate communication and cultural access to services for persons who are deaf, hard of hearing, late deafened, or deafblind.
- b. Continue to explore with the Advisory Council ways that the service system can appropriately refer individuals to culturally competent community and inpatient providers.

Goal 15: Expand and sustain services capacity necessary to provide services when and where they are needed, in appropriate amounts, and for appropriate durations.**Objectives:**

1. ***Establish services and supports that that minimize crises, reduce reliance on the most intensive levels of care, and promote independent living and individual and family choice.***

Action Steps:

- a. Develop strategies to address critical community service deficits, including the needs of individuals on CSB mental health, mental retardation, and substance abuse services waiting lists, the increasing costs and demands placed on the Community Services Pharmacy (formerly the Aftercare Pharmacy), and the inflationary pressures on services sustainability.
- b. Standardize emergency (crisis access) and stabilization services to best practices.
- c. Standardize case management and rehabilitation services to recovery-oriented and person-centered principles and practices.
- d. Support CSB efforts to acquire staff expertise and infrastructure needed to conduct thorough utilization management and review of the psychiatric inpatient services provided in state hospitals or purchased in local hospitals.
- e. Provide funds, as part of the Transformation Initiative, to support the purchase, renovation, or construction of transitional housing and other community-based diversion programs; provide one-time program start-up costs; implement evidence-based and best practices and retool existing services; and leverage other public and private infrastructure and capacity development resources
- f. Expand the number of purchased local psychiatric inpatient, psychiatric and medication, and intensive residential services delivered by all CSBs.
- g. Establish intensive community services capacity that provides alternatives to and timely discharge from psychiatric hospitalization and promotes community integration.
- h. Expand the number of discharge assistance project placements that enable individuals in state hospitals to transition to successful community placements.
- i. Establish, as an integral part of the implementation of the MR Services and Supports Model, intensive community capacity and behavioral consultation services that provide alternatives to training centers and promote community integration.
- j. Increase the number of individuals receiving MR Home and Community-based Waiver and family supports.
- k. Develop innovative ways to serve children and adults who have mental retardation but who are not eligible for the MR Waiver.
- l. Expand Part C early intervention services for infants and toddlers (ages 0-3) and their families to prevent or alleviate later developmental or learning problems.
- m. Implement additional systems of care projects to serve children and adolescents.
- n. Expand the number of guardianships CSBs support for individuals who require substitute decision makers in order to facilitate their transition from state hospitals to community services or to enable them to receive services for which informed consent is required.
- o. Assess the extent to which the core array of services and supports envisioned in the Integrated Strategic Plan is available and accessible in each CSB service area and support regional and CSB efforts to develop and align their existing services and supports with these services and supports.

2. *Establish funding mechanisms that blend funding streams and allow flexibility in creating individualized recovery-oriented and person-centered plans.***Action Steps:**

- a. Assess the extent to which federal and state requirements allow or prohibit blending or braiding of funding streams and whether waivers might be sought.
- b. Assess the feasibility of implementing self-directed care models in Virginia.

- c. Develop policies and procedures for integrating existing Department funding streams in ways that support individualized and flexible delivery of services and supports.

Goal 16: Promote and support the implementation of evidence-based practices.

Objectives:

1. *Develop shared commitment to adoption of consensus and evidence-based practices across the Department, CSBs, and state facilities.*

Action Steps:

- a. Develop commitment to the adoption of evidence-based practices through the Integrated Strategic Plan development process, the Department-CSB Partnership Agreement, and the Prevention Taskforce.
- b. Gain advocacy and other services system partners' support for the adoption of evidence-based practices through dialogue with the MH Planning Council, the Governor's Substance Abuse Council, NAMI-VA, MHAV, SAARA, Arc of Virginia, and other organizations.
- c. Adopt state policy defining service system expectations and incentives for the statewide adoption of best practices.
- d. Revise existing service definitions to incorporate best practices, where appropriate.
- e. Explore the potential for public-academic partnerships to support statewide implementation of best practices by all public sector providers of services.
- f. Explore the feasibility of realigning funding to support the delivery of best practices.
- g. Support research focused on the development of promising and best practices.

2. *Provide information and technical and evaluation assistance that supports the use of consensus and evidence-based practices in publicly funded services for persons with substance use disorders.*

Action Steps:

- a. In partnership with the Mid-Atlantic Addiction Technology Transfer Center, provide regional training to public providers that will assist practitioners in identifying and selecting appropriate consensus and evidence-based practices.
- b. Implement and maintain the Department's evidence-based practices web resources.
- c. Continue to provide onsite technical assistance to CSBs to develop, implement, and evaluate evidence-based practices.
- d. Continue to work with the SA Council of the VACSB to develop core standards for substance abuse services based on evidence-based practices.
- e. Continue to increase awareness of scientific advances that have implications for treatment through the Department's web page (pending implementation of a Department EBP site) and other methods of information dissemination.

3. *Develop approaches to identify, recognize, and reward evidence-based practices, e.g., programs and services that demonstrate positive individual outcomes.*

Action Steps:

- a. Allocate new funding for services based on achievement of strategic goals and individual outcomes.
- b. Work with services system partners to develop and implement methods to recognize and reward exemplary programs that demonstrate positive individual outcomes.

4. *Support development and adoption of evidence-based practices.*

Action Steps:

- a. Develop two or more Regional Community Support Centers with expertise in evidence-based practices.
- b. Explore opportunities with institutions of higher education to establish public-academic partnerships to develop one or more Regional Community Support Centers that will provide information, program and clinical consultation, and training and support to providers who adopt evidence-based practices.

5. *Increase Department capacity to apply for and secure grant funds to support adoption of evidence-based practices.*

Action Steps:

- a. Explore and strengthen partnerships with academic institutions and strengthen cross-disability collaboration to increase capacity to write grants and acquire grant resources.

6. *Increase the number of evidence-based prevention programs for youth and families that address the risk factors of availability of drugs, family management problems, and early alcohol, tobacco, and other drug use.*

Action Steps:

- a. Provide support and technical assistance in the selection, implementation, and evaluation of evidence-based prevention programs for youth and families.
- b. Monitor CSB provision of evidenced-based prevention programs for youth and families through the prevention database.
- c. Develop, publish, and distribute the *Directory of Virginia Prevention Researchers and Evaluators*, a resource guide for training and evaluation services in Virginia.
- d. Make available evidence-based prevention program materials and evaluation instruments through the prevention database and mail distribution.
- e. Support the development and recognition of Virginia prevention programs as model programs.

7. *Provide training in evidence-based clinical practices to CSB and state facility physicians and other treatment professionals.*

Action Steps:

- a. Host a series of training programs and symposia for community and state facility practitioners that feature national experts on the topic of evidence-based practices.
- b. Disseminate literature on the benefits and practice of evidence-based medicine to community and state facility medical directors and other clinical practitioners at regularly scheduled meetings.
- c. Disseminate available evidence-based practices and clinical guidelines to practitioners in community and state facility programs.
- d. Identify and feature practitioners in the public system and private practice who are using evidence-based practices as speakers at meetings, training programs, and symposia.
- e. Establish mechanisms for the sharing of information about evidence-based practices between community and facility psychiatrists an in the public and private sectors.
- f. Develop a training program to address the quality and risk implications of evidence-based practices for individual practitioners, their organizations, and the larger system.
- g. Periodically evaluate the utilization of evidence-based practices in community and state facility programs.
- h. Develop two centers of excellence in partnership with Virginia universities to provide workforce and program development, training, and consultation system wide.
- i. Support the participation of direct care staff in College of Direct Support training.

8. *Develop the capacity to train, credential, and compensate professionals who can offer Positive Behavioral Support (PBS) services.*

Action Steps:

- a. Complete the activities of the Positive Behavioral Support Services Workgroup.
- b. Work with affected agencies to adopt PBS as a best practice for people with mental retardation.
- c. Establish a credentialing agency with a curriculum approved to certify behavioral consultants.
- d. Provide training to raise awareness about the benefits of PBS in serving individuals with mental retardation.

Goal 17: Implement the MR Services and Supports by Level of Care Options model to strengthen the services delivery system for people with mental retardation.

Objectives:

1. *Apply consistent standards in determining the level of support needs of individuals with mental retardation.*

Action Steps:

- a. Work with the American Association on Mental Retardation to refine the Supports Intensity Scale (SSI) instrument to more effectively determine an individual's level of support needs.
- b. Identify other instruments that can be used in conjunction with the primary tool to assess level of support needs.
- c. Provide statewide training on the effective use of these instruments for determining level of support needs.

Goal 18: Assure that state hospitals and training centers provide quality assessment, treatment, rehabilitation, training, and habilitation services that are appropriate to the needs of individual patients and residents.

Objectives:

1. *Bring all state hospitals and training centers up to the active treatment and staffing levels provided in the Department's settlement agreements with the U.S. Department of Justice under the Civil Rights of Institutionalized Persons Act (CRIPA).*

Action Steps:

- a. Maintain compliance with provisions of the former DOJ settlement agreements at NVTC, ESH, NVMHI, CSH, and WSH.
- b. Address state facility staffing needs and align the entry salaries of Direct Service Associates.
- c. Address increased pharmacy costs, equipment and van replacement needs, and increases in gas and fuel costs for which funds are not currently budgeted.
- d. Support the efforts of the Office of the Inspector General to monitor the progress of state facilities in improving quality of care.

Goal 19: Make state facility medical and clinical expertise in geriatric medicine, child psychiatry, psychopharmacology, forensic psychiatry, and applied behavior analysis available to CSBs when and to the extent it is required.

Objectives:

1. *Develop a system that uses state facility medical and clinical expertise to provide consultation and assistance to CSBs in rural and clinically underserved areas.*

Action Steps:

- a. Convene a workgroup of state facility and CSB leaders to identify current and projected areas of service need.
- b. Assess the capacity of current medical and clinical staff to meet the specialized service needs of individuals served by CSBs in rural and clinically underserved areas.
- c. Identify the availability of specialized medical and clinical expertise in state facility programs by state facility service area.
- d. Develop strategies to provide state facility specialized medical and clinical staff for treatment and consultation services to CSBs that have current or projected shortages.
- e. Use state facility medical and clinical specialists to provide training to CSB personnel in identified areas of need, using interactive telecommunication networks and video technology.

Goal 20: Provide appropriate, effective, and efficient state facility pharmacy and Community Services (Aftercare) Pharmacy services.

Objective:

1. *Develop a Medication Management System.*

Action Steps:

- a. Implement bar coding and reading technology at each pharmacy.
- b. Assess physician prescribing practices, identify prescribing issues, and provide follow-up actions.
- c. Implement an inventory monitoring process to reduce excess inventories while ensuring the availability of normal stock levels for medications. .

2. *Evaluate and develop the system's capacity to fill Medicare Part D for individuals who participate in this federally funded program.*

Action Steps:

- a. Evaluate Medicare Part D and the impact to the Department and services system.
- b. Educate and train state facility pharmacists on Medicare Part D.
- c. Evaluate and insure that current system procedures and capabilities of state facility pharmacies comply with billing Medicare Part D requirements.
- d. Evaluate Medicare Part D approved private sector Prescription Drug Plans in Virginia with respect to the Department's drug usage and reimbursement received from CMS.
- e. Develop an automated process to identify Medicare and Medicaid recipients whose prescriptions are submitted to the Community Services (Aftercare) Pharmacy.

Goal 21: Ensure that CSB prevention services address risk and protective factors and service gaps identified by community-based prevention planning coalitions.

Objectives:

1. *Continue and strengthen the ability of community-based prevention planning coalitions to engage in an on-going prevention planning process and to select, implement, and evaluate evidenced based prevention programs that address prioritized risk factors.*

Action Steps:

- a. Increase support for community-based planning for prevention services by collaborating with other federal and state systems and participating in national and state organizations focusing on prevention.
 - b. Provide risk indicator data through the statewide youth survey, social indicator data bank, and Synar Inspection Report to community prevention planning groups for their identification of the most salient risk factors and problem adolescent behaviors.
 - c. Work with the Virginia Tobacco Settlement Foundation to administer a statewide youth survey process.
 - d. Review annually CSB prevention services plans provided by the Performance-Based Prevention Services data and written reports to ensure that prevention services address prioritized risk factors, are evidence-based, and are supported by collaborative and complementary services of other systems and groups.
 - e. Provide information and training on methodology and opportunities for collaborative prevention efforts.
- 2. *Increase opportunities to plan and implement prevention services at the state and local level.***

Action Steps:

- a. Share training, technical assistance, and planning resources with a variety of agencies and organizations invested in reducing substance abuse and dependence.
- b. Continue to build collaborative relationships at the state level and encourage and support collaboration at the local level to enhance environmental change and implement strategies that reduce exposure to risk and enhance protective factors.

Goal 22: Reduce the incidence and prevalence of suicide among youth and adults in the Commonwealth.

Objectives:

- 1. *Expand suicide prevention training and awareness activities targeted to youth and adults.***

Action Steps:

- a. Initiate implementation of the *Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia*.

Goal 23: Continue to reduce youth access to tobacco products.

Objectives:

- 1. *Continue to emphasize reduction of youth access to tobacco products as a legitimate prevention issue related to reduction of drug and alcohol abuse and improved health outcomes.***

Action Steps:

- a. Continue to educate youth about the harmful effects of tobacco use.
- b. Encourage support by the Virginia Tobacco Settlement Foundation of efforts to reduce youth access to tobacco products.
- c. Continue to support tobacco specific prevention strategies and activities.
- d. Develop a strategic prevention focus on regions reporting highest noncompliance.
- e. Continue to measure noncompliance in accord with the Synar Amendment.

Goal 24: Enable Virginia's mental health, mental retardation, and substance abuse services system to better understand and prepare for the heightened threat potential facing the Commonwealth.

Objectives:

- 1. Provide training to all CSBs and state facilities in crisis counseling and all hazards disaster response.***

Action Steps:

- Support CSBs efforts to develop, refine, and exercise their all-hazards emergency response plans and secure additional disaster training.
- Promote the involvement of state facilities in Virginia Hospital and Healthcare Association's regional hospital emergency preparedness councils.
- Provide training in crisis counseling program intervention basics and grant development to all CSBs.

Goal 25: Establish structures and relationships that will assure an immediate, effective, and coordinated response to terrorism-related and other major disasters by the mental health, mental retardation, and substance abuse services system.

Objectives:

- 1. Link CSBs, state and private facilities, school systems, public health departments, faith communities, professional organizations, academic institutions, and others into planning and response to disasters and terrorism-related events.***

Action Steps:

- Develop formal memoranda of understanding between contiguous CSBs to provide mutual support and response to disasters.
- Encourage and assist CSBs to develop strong supportive working relationships with other local mental health and substance abuse providers and first responders.
- Continue development of regional state facility evacuation plans.
- Assure that all state mental health and mental retardation facility disaster plans meet Joint Commission on the Accreditation of Healthcare Organizations standards.

- 2. Improve services system disaster response infrastructure and communication capabilities.***

Action Steps:

- Provide disaster preparedness and recovery training, assistance, and support to state facilities and CSBs
- Provide funding to support additional emergency response equipment for CSBs.

D. Partnerships for Services System Transformation

Current Services System Partnerships and Challenges

Over the past four years, the Department has worked to strengthen its partnerships with a number of state agencies, including the Department of Housing and Community Development (DHCD), the Department of Rehabilitative Services (DRS), the Department of Medical Assistance Services (DMAS), the Department of Social Services (DSS), the Department of Corrections (DOC), the Department of Criminal Justice Services (DCJS), the Department of Juvenile Justice (DJJ), the Virginia Department of Health (VDH), the Virginia Employment Commission (VEC), and the Virginia Housing Development Authority (VHDA). These partnerships are essential because the needs and challenges experienced by Virginians with

mental illnesses, mental retardation and substance use disorders extend beyond the public mental health, mental retardation, and substance abuse services system. A brief overview of Departmental activities involving these partners follows.

Medicaid: The Report of the President's New Freedom Commission on Mental Health, *Achieving the Promise*, indicates that states have relied heavily on financial support from the Federal Government for their mental health systems and, as a result, Medicaid is now the single largest payer of mental health services in the country (page 21). This is also true in Virginia; Medicaid is by far the largest single source of funds for community services across the state. The increasing prominence of Medicaid funding in CSB budgets has emphasized the importance of interagency collaboration in policy development, provider development, education and training of providers, development of quality assurance measures, and provider oversight. Virginia needs to take advantage of opportunities used by many other states to expand critically needed services that could be covered under Medicaid and to align existing services to recovery, resilience, and person-centered principles and practices.

Social Services: The Department works closely with DSS in a variety of programs and services that help individuals cope and recover from the effects of poverty, abuse, and neglect and achieve self-sufficiency. Several areas of collaboration include services to families who are TANF recipients, services to families confronting child custody issues, and services to substance-exposed infants and their families.

Housing: *The Olmstead Task Force Report* highlights the importance of assuring the availability of adequate supplies of affordable housing so people with disabilities can live as independently as possible in the communities of their choice. The Department has a long history of collaborative linkages and partnerships with VHDA, DHCD, the Disability Commission's Housing Workgroup, the Virginia Inter-Agency Council on Homelessness (VIACH), CSBs, and public and private housing providers to promote, enhance, and develop housing opportunities for individuals receiving mental health and substance abuse services. The Department also supports PATH outreach and engagement activities for individuals with mental illnesses who are homeless and recovery-focused housing alternatives, such as Oxford Houses, for individuals with substance use disorders.

Primary Health Care: There are a number of published studies showing that individuals with serious mental illness have higher rates of physical disability, significantly poorer health, and higher mortality rates than the general population (Golomb et al, 2000, and White, 1997). This is due in part to low income, a lack of health insurance, and the lack of access to adequate primary health care. Additionally, the new anti-psychiatric medications have troubling, severe side effects such as heart disease and diabetes. People with mental retardation of all ages have difficulty accessing primary health care due to a variety of factors, but, most prominently, individual communication issues and insufficient practitioner training in dealing with this population. Because physicians too often miss or misdiagnose a patient's substance abuse, the Department has developed and disseminated a toolbox comprised of a brief screening instrument and referral information to primary health providers. The Department also maintains partnerships with appropriate agencies and entities and has undertaken several initiatives with the Department of Health, the Virginia Primary Care Association, the Virginia Rural Health Resource Center, and the Virginia Association of Free Clinics to improve coordination between mental health, mental retardation, and substance abuse care and primary health care.

Employment Services and Supports: Adults with a serious mental illness and youth with serious emotional disturbances face challenging obstacles to obtaining and maintaining competitive employment. This is also true for individuals with mental retardation and substance use disorders. Pervasive stigma, the limited availability of the evidence based practice of supported employment, fear of losing health insurance coverage, complicated funding streams,

and poorly coordinated vocational assistance programs are some of the many factors that overwhelm individuals attempting to secure employment or employment services. Joint mental health and substance abuse employment initiatives between the Department and DRS provide specialized vocational assistance services in CSBs. A multi-agency initiative involving the Department, DMAS, DRS, and the academic community has developed WorkWORLD™ decision support software designed to support people with disabilities who are making decisions about gainful work activity and the use of work incentives.

Criminal Justice and Juvenile Justice Services: In too many cases, the criminal justice system has become the primary source for mental health care. In ongoing efforts to improve screening, ensure appropriate treatment and supports, and enhance interagency planning and coordination to better meet the needs of individuals involved with the criminal justice system, the Department maintains strong working relationships with DOC, DJJ, and DCJS. DOC works closely with the Department to improve access to hospital and community treatment resources that have been released from DOC facilities and screens inmates who are potentially eligible for civil commitment to the Department as sexually violent predators. DCJS has partnered with the Department to develop and implement cross training in mental health evaluation and treatment methods for law enforcement personnel, including jail security staff. Additionally, Department central office and state facility staff work with the Virginia Office for Protection and Advocacy (VOPA) to ensure protections and advocacy for the human and legal rights of individuals with mental, cognitive, or developmental disabilities.

At the local level, these critical partnerships include school systems, social services, local health departments, and area agencies on aging. Services provided by these local agencies are critical to the success of individuals with mental illnesses, mental retardation, and substance use disorders, including Medicaid MH services, MR Waiver services, auxiliary grants for adult living facilities, Medicaid eligibility determinations, various social services, guardianship programs, health care, vocational training, housing assistance and services for TANF recipients. Some local agencies participate in Part C local interagency coordinating councils and provide Part C services to infants and toddlers.

Many of these state and local agency representatives participate as members of state and regional planning committees, including the Special Populations Workgroups and the Regional Strategic Planning Partnerships focused on transforming the services system.

Partnerships with Private Providers

Private provider participation in the services system is another major strength of the public mental health, mental retardation, and substance abuse services system. This participation has grown dramatically over the last six years. A major factor influencing this growth has been the continued although, less rapid expansion of Medicaid MR Waiver services.

Despite this significant expansion, two limiting phenomena have been apparent in this process: the absence of private providers in certain parts of the state and the need for private providers to offer more of particular types of services. Consequently, the development of private providers needs to be fostered and supported in various parts of the state. This includes encouraging existing private providers to expand their operations to other parts of the state, to begin offering other services, and to increase their current capacities. This also includes identifying and, where possible, offering incentives to promote the development of new private providers. These initiatives should be joint efforts by the Department and CSBs, working closely with the private provider community.

A number of conditions have limited, reduced or jeopardized private provider participation in the publicly funded mental health, mental retardation, and substance abuse services system.

Medicaid State Plan Option and MR Waiver reimbursement rates, with only a few exceptions, have not been adjusted in over 13 years. In some areas of the state, Medicaid fees reportedly do not cover the cost of providing services; consequently, private providers are not able to offer those services on an economically sustainable basis.

Third party insurance coverage for services continues to decline under managed health care, in terms of services covered, amounts of services allowed, and amounts paid for services.

A growing proportion of individuals have inadequate or no health insurance coverage.

Information about potential private providers may not be readily available to CSBs when their staffs are developing individualized services plans.

There is a perceived or actual resistance by some private providers, especially residential or inpatient providers, to serving individuals receiving CSB services, because of the severity of the individuals' disabilities or lack on information about effective treatment modalities.

Market forces have led to shifts in private sector service provision, despite the obvious and significant public sector needs for particular services. A clear and immediate example of this condition is the marked and continuing reduction in local private psychiatric inpatient hospital beds in some parts of the state that are available to CSBs and the Department. Some providers have ceased offering this service due to inadequate reimbursement rates; others have converted their inpatient beds to other uses, such as Comprehensive Services Act residential beds, which may be less costly to operate and more easily reimbursable.

Like public providers, the private sector is experiencing increasing difficulties in recruiting and retaining qualified staff, including professionals, such as nurses and other clinical staff, and para-professionals, such as residential aides and personal care staff.

The large capital cost sometimes associated with the implementation of new services, particularly residential services, may inhibit private sector participation.

Finally, the significant start up costs, such as staff recruitment and training, equipment purchases, acquisition of space, and operating at less than full capacity during implementation that are often required to initiate a new service may make it difficult for smaller providers to do so, limiting their participation in the publicly-funded services system.

Partnerships with Community Services Boards and Local Governments

The Department took a new approach in developing the FY 2004 Community Services Performance Contract. In collaboration with CSB representatives, Department staff developed the new contract from a blank slate, rather than just revising the previous year's contract. This produced a greatly shortened and more focused FY 2004 Performance Contract. It also produced two new documents, the *Partnership Agreement* and the *Community Services Contract General Requirements Document* and a new document, the *Central Office, State Facility, and Community services Board Partnership Agreement*.

The Partnership Agreement describes the values, roles, and responsibilities of the three operational partners in the public mental health, mental retardation, and substance abuse services system: CSBs, state facilities, and the Department's central office. It reflects the fundamental, positive evolution in the relationship between CSBs and the Department to a more collegial partnership. It recognizes the unique and complementary roles and responsibilities of the Department and the CSBs as the state and local authorities for the public mental health, mental retardation, and substance abuse services system. The goal of the agreement is to establish a fully collaborative partnership process through which the CSBs, central office, and state facilities can reach agreements on operational and policy matters and issues.

The partners entered into the agreement to improve the quality of care provided to individuals and to enhance the quality of individuals' lives. While they are interdependent, each partner works independently with both shared and distinct points of accountability, such as state, local, or federal government, other funding sources, individuals, and families, and all partners embrace common core values.

The 134 cities or counties in Virginia continue to be vital members of the state-local partnership that enables the provision of community mental health, mental retardation, and substance abuse services to more than 185,000 Virginians annually. Local governments partner with the Commonwealth through the CSBs that they established and maintain and through their financial and other support of services offered by those CSBs. The Department needs to continue communicating with local governments through their CSBs about their concerns and ideas, such as ways to enhance service quality, effectiveness, and efficiency. As demands for services continue to exceed the capacity of the current services system to meet them and as related requirements for more effective management and coordination of services proliferate, new and innovative approaches need to be considered that preserve the strengths and advantages of the current public services system and the state-local partnership, while responding to these new demands.

System Leadership Council

The System Leadership Council evolved from the FY 2001 community services performance contract negotiations, reflecting a desire to include a mechanism in the contract for providing continuity, enhancing communication, and addressing systemic issues and concerns. Based on that contract, the Department established the System Leadership Council in August 2000. The Council includes representatives of the CSBs, state facilities, local governments, the State Board, and the Department's central office. In 2005, the Council added three new members to represent individuals with mental illness, mental retardation, and substance use disorders. This action responds to and helps implement the vision of a person-centered system that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of individual participation in all aspects of community life.

The Council continues to serve as a coordinating mechanism to discuss issues and problems from a systemic point of view, providing continuity, enhanced communication, and a consistent perspective over time. The Council's work and recommendations affect the organization and delivery of publicly funded services in Virginia. The Council continues to discuss a broad range of issues and support various initiatives, including performance contract and reporting requirements, workforce concerns, pharmacy and medication issues, discharge protocols, and inpatient utilization review and management. In recent years, the Council has focused on reinvestment and restructuring activities and the system transformation initiative, plus the Integrated Strategic Plan that will guide this initiative.

In 2005, the Council reaffirmed its focus on long-term, strategic issues and concerns. To address more immediate issues, the System Operations Team was established. The team coordinates the service's system's response to programmatic and operational issues and acts as a problem-solving group. The team includes Department, CSB, and state facility staff.

Goals, Objectives, and Action Steps

Goal 26: Realize cost savings to the Commonwealth by expanding Medicaid funding for community mental health, mental retardation, and substance abuse services.

Objectives:

1. *Align Medicaid mental health, mental retardation, and substance abuse services with recovery and resilience principles and practices and expand opportunities for individual and family participation in individual-directed services.*

Action Steps:

- a. Maximize opportunities within the State Medicaid Assistance Plan to incorporate recovery, resilience, and person-centered practices into targeted case management and state plan option service definitions.
- b. Participate with DMAS, CSBs, and the Virginia Hospital and Healthcare Association in an examination of the impact of existing reimbursement rates on the ability of local hospitals to provide psychiatric services.
- c. Participate with DMAS, CSBs, and the Joint Legislative Audit and Review Commission in an examination of the impact of existing reimbursement rates on the ability of private and public providers to provide MR Waiver services.
- d. Work with DMAS to revise the MR Waiver to increase flexibility and address issues with the current waiver (e.g. coverage for general supervision).
- e. Develop mechanisms with DMAS to assure Department participation in the development of Medicaid procedures and regulations that affect behavioral health (e.g., substance abuse treatment covered through EPSDT benefits).
- f. Develop mechanisms with DMAS that ensure providers receive appropriate training and communications regarding approved substance abuse treatment services (e.g. services for pregnant and postpartum women and adolescent substance abuse treatment through EPSDT).
- g. Maximize opportunities within the State Medicaid Assistance Plan to provide Medicaid coverage for substance abuse services for persons with co-occurring MI/SUD.
- h. Maximize opportunities within the State Medicaid Assistance Plan to provide Medicaid coverage for peer drop-in programs.

Goal 27: Increase the stability of families affected by mental illnesses and substance use disorders that are receiving TANF benefits or are involved in protective services.

Objectives:

1. *Provide mental health and substance abuse services to families involved in TANF, ASFA, or other social services initiatives.*

Action Steps:

- a. Improve identification and assessment strategies.
- b. Improve matching of individual needs to service type, intensity, and length of treatment.
- c. Expand opportunities for cross-training and other methods of technology transfer.
- d. Utilize the interagency Safe Families in Recovery Strategic plan and Memorandum of Understanding to facilitate planning and collaboration.

Goal 28: Provide safe and affordable housing that meets the needs of individuals receiving mental health, mental retardation, or substance abuse services.

Objectives:

1. *Expand safe and affordable housing alternatives.*

Action Steps:

- a. Provide ongoing assistance to CSBs and publicly funded services providers in accessing federal resources to meet the housing and community-based supports needs of individuals receiving services.

- b. Continue to provide information to CSBs about grants and other funding opportunities that provide resources to meet housing needs.
- c. Work with the VHDA, DHCD, and other agencies to maximize the use of all available housing resources and collaborate with them to design and implement affordable housing development plans for the benefit of low-income and homeless Virginians with mental disabilities.
- d. Continue to meet with VHDA, DHCD, CSBs, centers for independent living, disability services boards, and area agencies on aging to understand local and regional housing needs and strategies and priorities for state resources.

2. *Provide safe, substance-free affordable housing to persons in recovery through existing and new Oxford Houses.*

Action Steps:

- a. Contract with Oxford House, Inc. or a similar organization to provide loan management services and technical assistance to individual Oxford Houses.
- b. Provide technical support to existing Oxford Houses and to communities interested in establishing and collaborating with Oxford Houses.
- c. Continue to support the loan fund.
- d. Continue to establish relationships with individual Oxford Houses.
- e. Encourage networking among established Oxford Houses.

Goal 29: Improve the physical health and wellness of individuals receiving mental health, mental retardation, or substance abuse services.

Objectives:

1. *Support and expand partnerships between providers of physical health and mental health, mental retardation, or substance abuse services.*

Action Steps:

- a. Provide training and education to state facility and community psychiatrists aimed at increasing their awareness of potential severe side effects, such as heart disease and diabetes, of the new anti-psychotic and other medications.
- b. Support the development of formal agreements and cross-referral networks between CSBs and free clinics, federally funded health centers, and other providers of primary care services.
- c. Encourage state facilities and CSBs to consider wellness strategies in individuals' service planning.

2. *Improve the identification, screening, and diagnosis of substance use disorders and referrals to services by providers of primary health care services.*

Action Steps:

- a. Continue to seek resources and collaborative partners for technology transfer to providers of primary health care services.
- b. Continue to refine and revise "packaged" materials, such as the Substance Abuse Toolbox.
- c. Develop multi-media, multi-staged approaches to education primary care providers.

Goal 30: Reduce barriers to employment for youth and adults with mental disabilities.

Objectives:

1. ***Increase access of individuals, family members, case managers, and public and private vocational and employment-related services providers to accurate information on existing SSI and SSDI work incentives.***

Action Steps:

- a. Strengthen the linkages to and utilization by individuals receiving mental health services, CSB case managers, and community support and psychosocial rehabilitation services staff to SSA benefits planning, assistance, and outreach providers and individualized benefits assistance planning.

2. ***Address the fears of individuals receiving services about the loss of health insurance and prescription coverage if earned income exceeds benefit thresholds.***

Action Steps:

- a. Continue to work with DSS, DRS, and DMAS to increase utilization of continual Medicaid coverage for individuals on 1619 (b) status with the Social Security Administration.
- b. Continue to disseminate information, provide resources, and draft letters for use by individuals and case managers to assure continuation of Medicaid coverage as allowed by section 1619 (b) when individuals' earned income exceeds SSI thresholds.
- c. Continue to collaborate with the Disability Commission, DRS, DMAS, mental health constituency groups, and others in the development of a Medicaid Buy-In for Virginia.
- d. Continue to promote widespread utilization of Virginia's customized WorkWORLD™ Software by employment services providers.

Goal 31: Improve competitive employment opportunities and outcomes for individuals receiving mental health, mental retardation, or substance abuse services.

Objectives:

1. ***Improve knowledge about evidence-based employment practices for youth and adults with serious emotional disturbances and mental disabilities.***

Action Steps:

- a. Provide mental health community support, psychosocial rehabilitation, vocational, PACT, and other providers with information and knowledge on approaches to supported employment and the individualized placement and supports model of employment services.
- b. Link mental health providers with existing Internet web-based instruction and courses on supported employment principles, services, and supports.
- c. When available, disseminate the *Evidence-Based Practices Supported Employment Implementation Resource Kit* to public and private community mental health support services providers, DRS, and other entities as appropriate.

2. ***Expand the availability of evidence-based supported employment services and supports for youth and adults with mental disabilities.***

Action Steps:

- a. Identify inter-agency financial and organizational barriers to implementing evidence-based practices of supported employment for adults with serious mental illness.
- b. Encourage state agencies and others to clearly identify and articulate employment-related services and supports that can be supported by each state agency's respective funding streams and subsequently plan, develop, and implement joint training initiatives on this for individuals, family members, and providers.

- c. Collaborate with DMAS to ensure that Virginia's Medicaid Rehabilitation Option incorporates all allowable employment-related services and supports, in accordance with the CMS and CMHS recognized evidence-based practice of supported employment for persons with mental illness.
 - d. Strengthen the emphasis on vocational and employment services and supports for individuals with a mental illness prior to discharge from a state hospital to the community and for all youth and adults with mental disabilities at intake to community mental health programs.
 - e. Continue to identify and, as appropriate, collaborate with DRS and other entities on federal and other grant applications that present opportunities for enhancing employment services, supports, and outcomes for young adults and individuals with a serious mental illness.
 - f. Continue to support organizations of individuals receiving services as providers of employment services and supports.
 - g. Continue collaborative efforts with DRS to increase access to vocational services, job training, and rehabilitation for individuals with mental disabilities, including cross-training initiatives for respective staff.
- 3. *Expand the interagency agreement between the Department and DRS to include more CSB vocational assistance service sites for individuals receiving substance abuse treatment services.***

Action Steps:

- a. In collaboration with DRS, evaluate the impact of the agreement on employment, employment stability, and clinical outcomes.
- b. Continue to provide technical assistance to CSBs participating in the agreement.
- c. Continue to provide technical assistance and training to DRS counselors providing services through the agreement.
- d. Enhance services as indicated by evaluation data.

Goal 32: Encourage and facilitate greater private provider participation in the public mental health, mental retardation, and substance abuse services system.

Objectives:

- 1. *Identify ways to increase the number of private providers participating in the publicly managed services system and to expand the array of services they offer.***

Action Steps:

- a. Urge DMAS to increase current reimbursement rates for Medicaid State Plan Option and MR Waiver services to increase the availability of services and encourage greater private sector participation in the publicly funded services system.
- b. Work with DMAS to identify and implement strategies for ensuring that Medicaid managed care plans permit the provision of adequate types and amounts of necessary services and reimburse providers for the reasonable costs of delivering services.
- c. Work with all affected partners (e.g., CSBs, the Virginia Hospital and Healthcare Association, health planning agencies, individuals, families, and advocacy groups) to identify and implement regional and statewide strategies for ensuring the availability of an adequate number of local acute psychiatric beds and appropriate alternatives that could serve individuals in need of acute psychiatric services in their communities.
- d. Continue to work with CSBs and private providers to address workforce issues affecting the availability of adequate numbers of quality staff in community services.
- e. Ensure that funding requests contain sufficient provisions for necessary start-up

expenses (e.g., staff recruitment and training, equipment purchases, acquisition of space, and operating at less than full capacity during the implementation phase) and for maintaining services after they are implemented (e.g., salary increases and inflation adjustments).

E. Infrastructure and Technology

State Facility Capital Issues and Priorities for Facility and Associated Community Infrastructure Development

State hospitals and training centers will continue to be essential components of Virginia's publicly funded services system. The Department is committed to achieving a best practices balance between community and state facility services. As part of that balance, the Department must ensure that state facilities are safe, efficient, well maintained, and appropriately designed to meet the needs of individuals receiving services in them.

The Department operates 16 facilities located in 12 geographic areas, with 412 buildings encompassing about 6.5 million square feet. The average age of all state facility buildings is 49 years, with a median age of 55 years. Maintenance and renovation funding has not been adequate to prevent a gradual decline in the condition of state facility buildings over the years. Most buildings require replacement of their HVAC, fire alarm, and electrical systems and are generally in poor condition.

Over the past decade, the census of most state facilities has dropped. State facility programs and individual profiles also have changed dramatically. Historically, state hospitals provided long-term care, using a custodial model. Today, with increased reliance on community-based programs, state hospitals are providing shorter term, more intensive, active treatment - with the goal of returning individuals to their home communities as soon as clinically appropriate. Similarly, the population currently served in training centers has changed, with the majority of current residents functioning at severe and profound levels of mental retardation. Many individuals served in training centers are non-ambulatory, requiring specialized wheelchairs. They have multiple complex medical conditions such as seizures, scoliosis, or sensory deficits that require specialized equipment. These medical needs are projected to increase as the training center population ages. In addition, training centers are experiencing greater demands to serve persons who have mild or moderate mental retardation but also have challenging behaviors that require significant behavioral interventions. All of these factors affect current and future spatial requirements and configurations of state facilities.

A commensurate change in state facility physical plants has not occurred, and many currently occupied buildings are not appropriate for the types of individuals who now need state facility services. Many of these buildings also are inefficient to operate. Where previously there was a need for a multi-building campus setting, opportunities now exist to provide services within a single building at a greatly reduced cost. State training centers, particularly, need to be redesigned to serve individuals with the most severe and profound disabilities and those with behavioral challenges that make it difficult to find community placements.

The Department also must bring existing state facility living areas up to current life safety standards. Some buildings lack the space and accommodations for adaptive equipment that is appropriate for the level of physical disabilities experienced by persons now receiving facility services. Other buildings lack current fire detection systems and other early detection safety systems. These buildings require major renovations to bring them into compliance with current codes and certification requirements.

The Department's Capital Improvement Plan has two essential components: the first proposes projects necessary to keep operational buildings in use for the next two biennia, including roof, utility, HVAC, and food service repairs and environmental hazard abatement; the second is a phased program of facility replacements. Training centers that do not meet code requirements and are not appropriately configured to meet the needs of their current populations would be replaced with new facilities. Sprawling state hospital campuses would be replaced with smaller, more effective and efficient single-building facilities. Training centers also would provide community support for medical, dental, vocational, speech, occupational and physical therapy, rehabilitation engineering, and staff development and training in the community residential programs. Appendix G provides a listing of the Department's proposed capital priorities for 2006-2012.

Information Technology Issues and Priorities

The Department's information technology resources are being restructured for applications development and support following the transitioning of agency staff to VITA in 2004. For the central office and state facilities, this change has brought about significant challenges. Supporting out-of-scope services has frequently been difficult. The Department maintains 22 production application information technology systems, among them:

The state facility information system (AVATAR), which was developed in 2003 to ensure compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Sets Privacy Rule, is in production and producing monthly reimbursement billing on schedule.

The Department, in partnership with the CSBs, has successfully implemented the Community Consumer submission (CCS) extract software, which enables the Department to comply with federal and state reporting requirements. The update to this software, to incorporate new federal requirements was developed in 2005.

The FMS Migration is underway and on schedule and budget and should be completed by June 2006.

The Department's technology environment and staff are transitioning from supporting legacy applications using older technologies to developing and supporting new applications using current technology. This includes development of a structured applications development environment, standardization of development tools, and provision of adequate training and support for the technology staff. Applications written in the mid 1990s need to be re-written to a more robust software/database platform. For example, applications that had to be written quickly to meet a business need were developed using MS-Access with the intention of converting them to a more powerful and complex platform in the future. Since then, the functionality, as well as the number of records, has increased to the point where system performance is no longer acceptable. Additionally, applications within the Department are not well integrated. This impairs data reporting and analysis efforts as well as applications maintenance and enhancements that must be done by technology staff. Also, a significant amount of state facility data must be migrated from an obsolete hardware platform so that critical reporting functions will not be interrupted.

The Department currently has 10 active application development projects. Two of these projects have objective outcome measures (project plan, monitoring, scheduling, and budget) and both are utilizing best business development practices (primarily VITA standards). The remaining eight projects are not following VITA standards at this time. In March 2005, staff began a formal process to determine and develop needed best business practices and procedures that comply with VITA standards for new projects and application maintenance activities. These practices and procedures will address measures for productivity and

documentation requirements for project planning activities. They are scheduled for completion in late 2005 and will include:

- System Development Life Cycle (SDLC)
- Project Charter
- Documentation requirements for each SDLC phase
- Project Planning Requirements
- Customer approvals
- Progress reporting
- Change control
- Security
- Testing.

The HIPAA Security Rule implementation is behind schedule by about two months due to resource availability and conflicting priorities. Implementation policies and procedures are nearing completion.

The Department's technology infrastructure requires upgrading. A number of state facilities need to upgrade hardware, software, and network cabling. Supporting this infrastructure is very difficult. In order to provide secure and adequate support to address the needs of Department staff and individuals receiving services, it is critical that the following infrastructure requirements be addressed.

Maintain current levels of software to include operating systems, applications development software, and desktop software.

Develop and utilize standard technology products to ensure seamless implementations of applications software and to promote interoperability. This includes hardware, operating systems, applications development and desktop software, and networking hardware and software.

Establish and maintain adequate cable plants utilizing technology that provides secure and efficient network services to appropriate staff.

Begin consolidation of technologies to reduce costs and improve service.

Monitor network and server performance to ensure and maintain availability of services.

Continue to implement Department-wide applications in order to streamline operations and eliminate redundant efforts.

Establish service level agreements to ensure and develop means to measure satisfaction with services provided.

A number of external requirements are affecting the Department's information technology capability, including:

Federal reporting requirements for outcome measures will require changes to the Department's MH, MR, and SA information technology services applications.

Federal requirements for an electronic health record are being considered. These requirements would impact technology needs in state facilities and CSBs.

Requirements for medication management will require the Department to upgrade or replace its automated pharmacy system in state facilities and the Community Services Pharmacy. This includes medication bar coding.

Security management (HIPAA, Homeland Security) will require additional resources in the central office and state facilities.

To address these issues, the Department is establishing a structured information technology applications development environment. This environment will employ standard development and maintenance procedures and a standard set of development tools. Staff training and retraining will be a priority. This effort should result in more consistent applications that lend themselves to better integration and a more productive staff. This effort will also address some of the issues created by the VITA transition. Enhancements to data reporting and analysis processes to integrate data from multiple sources will be made, such as data warehousing and data migration from obsolete platforms. The Department will design and develop a set of applications to address the outcome measurement requirements for mental health, mental retardation, and substance abuse services. These applications will be integrated with the CCS application. Resources will be identified or obtained to support the security management process. This will free current resources to address issues related to supporting out-of scope services.

The Department IT Strategic Plan is proposing the following major IT projects:

Clinical Applications – Electronic Health Record: This project involves the purchase of a comprehensive clinical information system for behavioral healthcare that manages the care data of individuals receiving state facility services. In order to properly manage care provided, clinical data in the form of thousands of transactions per facility per day must be collected, stored, and analyzed using an electronic medical record. This system would be implemented at all state facilities and in the central office. It would eliminate the manual data processes that are still used in many clinical areas. An electronic health record, supported by a suite of clinical applications, will greatly reduce risk while increasing operational efficiencies, cost savings, and individual satisfaction.

State Facility Pharmacy and Community Services Pharmacy System: This project would replace an outdated stand-alone pharmacy system with one that can assist in adequately managing the accurate and safe dispensing of medications to individuals. The replacement system would manage pharmacy functions, including prescription entry, medication dispensing, inventory control, reimbursement, and quality assurance. For the state facilities, the replacement system would be integrated with the Department's existing AVATAR system, which is used for individual admissions, discharges, and reimbursement functions.

Mental Health, Mental Retardation, and Substance Abuse Services Outcome Information System: This project would provide processes that permit the Department's mental health, mental retardation, and substance abuse services offices to access CCS data system (the core set of data on individuals served in CSBs) and other data needed for federal reporting and program analysis. The application would utilize data from multiple sources and create applications to access other data sources that are necessary to meet federal reporting requirements. Federal reporting mandates require that mechanisms be in place by December 2007 to measure individual outcomes. The implication is that federal funds would be in jeopardy if the proposed applications were not in place.

Goals, Objectives, and Action Steps

Goal 33: Assure that the capital infrastructure of state hospitals and training centers is safe, appropriate for the provision of current service methods, and efficient to operate.

Objectives:

- 1. Improve the capital infrastructure of state hospitals and training centers to assure their compliance with life safety and applicable building codes and their appropriateness for active treatment and habilitation services.***

Action Steps:

- a. Implement critical state facility repairs that are necessary to maintain certification or meet JACHO standards.
- b. Develop intensive service centers and intensive service homes based upon the MR Services and Supports Options by Level of Care Model.
- c. Develop new state hospital designs that more appropriately and efficiently respond to the needs of individuals receiving services
- d. Continue to update individual state facility master plans to respond to the programming needs of individuals.

Goal 34: Improve the ability of the Department, state facilities, and CSBs to manage information efficiently in an environment that is responsive to the needs of users and protects identifiable health information for individuals receiving public mental health, mental retardation, or substance abuse services.

Objectives:**1. *Implement the Department's Information Technology Strategic Plan.*****Action Steps:**

- a. Maintain a positive working relationship with VITA.
- b. Implement VITA standards necessary to assure a structured information technology applications development environment.
- c. Employ standard development and maintenance procedures and a standard set of development tools.
- d. Invest in information technology staff training and retraining.
- e. Design and develop a set of information technology applications to support transformation implementation activities and address outcome measurement requirements for mental health, mental retardation, and substance abuse services.
- f. Implement a data warehouse that provides a common repository for storing integrated financial, clinical, and operational data across all state facilities and a decision support system offering "point and click" access to the data warehouse.
- g. Address agency infrastructure requirements related to current operating systems and software, interoperability, security, network and server performance, potential areas for consolidating or streamlining, and user satisfaction.
- h. Convert existing applications to platforms that allow more powerful and complex performance.
- i. Implement a pharmacy information system for state facility pharmacies and the Community Services Pharmacy.

2. *Meet federal expectations regarding the implementation of Electronic Health Records across the services system.***Action Steps:**

- a. Work with the CSBs and state facilities to promote the rapid development of a model Electronic Health Record based on federal, state, and third party payor source demand.
- b. Participate in a pilot program to connect Electronic Health Records across clinical sites, including CSBs and a state facility in one region and evaluate the usefulness of an automated records system.
- c. Develop an Electronic Health Record supported by a complete set of clinical applications in all state facilities.

F. Human Resources Management and Development

Recruitment and Retention of Hard to Fill Positions

There are several major human resources-related factors that are expected to affect the quality, responsiveness, and effectiveness of services provided through Virginia's publicly funded services system. These include:

- The aging and increasing cultural diversity of the current workforce,
- Declining enrollments in key degree and specialty academic programs such as nursing,
- The shortage of health care professionals and direct care workers, and
- The increasing level of skills expected of the workforce in the future.

A rapidly changing and more entrepreneurial economy has placed a premium on both workforce adaptability and flexibility. Technology advances will increase the demand for highly skilled and well-educated workers. Workers able to master technology and cope with change will have an advantage. The economy's increasing emphasis on services will continue to create many new jobs that will be filled by workers who span the spectrum from highly skilled to moderately skilled workers, including many who might be candidates for recruitment by state facilities and community programs. Companies that cannot compete in the marketplace, even those that once had been monopolies, will not survive. As a result, workers will likely change jobs, employers, and even occupations more often than in the past. Workers in all occupations will need to prepare themselves mentally and professionally for this uncertainty.

With continuing budget pressures at the state and community levels, the overall size of Virginia's services system's workforce is projected to grow slowly. This will place pressure on public and private providers to increase the productivity of individual workers. Increased productivity can be accomplished by technology improvements, better matching of workforce skills with individual provider needs and individual acuity levels, and increased emphasis on education about new treatment modalities and professionally accepted clinical practices. A variety of education and compensation incentives will be needed to enhance skill levels and retain workers in key health care occupations, including expanded use of career ladders; on-site formal education for nurses, health care aides, case managers, and other licensed providers; tuition reimbursement; and grants for off-site educational programs. The community college system has expressed an interest and willingness to assist in this educational effort.

As Virginia's population becomes more diverse, providers must increase the cultural competence of workforce members. In July 2001, the U.S. Department of Health and Human Services Office of Minority Health released national standards on Culturally and Linguistically Appropriate Services (CLAS) in health care. These standards address culturally competent care, language access services, and organizational supports. Within this framework, these standards have three levels of stringency: mandates (intended for all recipients of Federal funds), guidelines, and recommendations. There is a federal mandate to identify the non-English languages that are used by individuals who access health and social services. Services providers must identify the:

- Language needs of individuals receiving services who have limited English proficiency,
- Points of contact in the organization where language assistance is likely to be needed, and
- Availability of resources and ways to access them to provide timely language assistance.

A multi-agency response to identify and provide trained and competent interpreters and other language assistance services may be appropriate and a more efficacious use of resources to ensure staff training.

The continuing shortage of nurses has the potential to have significant service and financial impact on Virginia's publicly funded mental health, mental retardation, and substance abuse services system. The services system is having increasing difficulty attracting and retaining nurses, particularly in the area of mental health. This difficulty is being experienced by state facilities and community services providers across the Commonwealth.

In March 2003, the Department conducted a workforce survey of the 15 state facilities, the 40 CSBs, and approximately 400 private providers across the Commonwealth. Responses were received from 31 percent of survey recipients. Almost half (48 percent) of the respondents indicated that they do not feel that it is relatively easy to obtain Registered Nurses or to retain well qualified Registered Nurses. Forty-eight percent did not feel that professional growth and development training opportunities are sufficient for Registered Nurses. The same percentage (48 percent) agreed that the system's public image has had a negative influence on the recruitment and retention of Registered Nurses. Some organizations have reported a turnover rate reaching as high as 26 percent. In FY 2005, turnover rate at state facilities reached as high as 40 percent. This has resulted in significant overtime and contractual costs. Workforce development initiatives addressing these issues follow.

- Demonstration sites to encourage entry level and continued learning for DSPs, CNAs, LPNs, and RNs into and within the system;
- Career ladders or pathways;
- System-wide public awareness campaign;
- Recognition programs; and
- Partnerships to seek funding resources.

Demand for human services direct cares support positions, such as Direct Services Associates in state facilities, is growing more than twice as fast as all other industries. Virginia's services system is unable to meet current demand for direct care workers who provide essential hands-on care to individuals who must depend upon others for the most basic activities of daily living. At the same time, service requirements and competencies have increased significantly for direct care support staff. The inability of providers to attract, train, and retain qualified direct services support staff has been identified by all oversight entities. This problem affects state facilities, CSBs, and private programs, including Medicaid-funded services.

Turnover to alternate employers continues to worsen, ranging from 26 percent to 49 percent in some system providers. Over 61 percent of the Department's workforce survey respondents stated that it was not easy to obtain direct service workers. Two-thirds (66 percent) indicated that it was not easy to retain well-qualified direct service workers. Over three-fourths (79 percent) said that competition was high from other area employers. Thirty-five percent indicated that professional growth and development training opportunities were not sufficient. The same percentage (35 percent) stated that the system's public image was not a positive influence on recruitment/retention of direct care personnel. The following workforce development initiatives are addressing these issues:

- Continued learning programs utilizing long-distance learning techniques,
- Career ladders or pathways linked to educational awards, e.g., certificates, specialized diplomas, AAS or AA degrees,
- Public awareness campaigns to educate and recognize direct care services and opportunities offered by the services system, and
- Partnerships to seek funding resources.

Many public and private providers have not been able to attract and adequately compensate staff or to provide training and development needed for career growth. Current reimbursement

rates no longer cover the costs of providing health care services. Providers experience extra costs associated with overtime, contract employees, and continuous recruitment and training due to excessive turnover. This has limited the ability of those providers to give needed levels of care and to assure health and safety. Some public and private providers are being financially burdened to the point of reducing capacity or going out of business.

The Department, state facilities, CSBs, and private providers have established an ongoing partnership through the Workforce Steering Committee to jointly address continuing services system workforce issues, such as compensation, public image, access and availability of basic and continuing education for the nursing profession, lack of career ladders, availability of qualified candidates for key specialty roles in treatment settings, aging of the workforce, short tenure of the current workforce, increasingly physically and mentally demanding work environments, and market competitiveness for qualified candidates. The steering committee needs to continue to focus its efforts to strengthen the status of the direct support role and industry image; educate, train and develop frontline staff; develop career paths linked to education and training; secure systems change by improving income, linking wage enhancements to skill development; and revise public policy to provide the necessary tools for a transformation of the direct care worker to a direct care professional.

Training and Skill Development

Substance Abuse: Technological progress that has fueled advances in evidence-based practices also has produced an urgent need for a well-trained workforce. At the same time, the existing workforce is “aging out” and is not being replenished with younger workers. Technology transfer to the existing workforce and the attraction and retention of a younger workforce are critical issues in the field of treatment for substance use disorders. To address these issues, the Department has joined forces with the Mid Atlantic Addiction Technology Transfer Center (Mid-ATTC), one of 14 such centers in the nation supported by the federal Center for Substance Abuse Treatment, to bring science to practice by accelerating the time it takes for new scientific discoveries to be integrated into mainstream treatment for substance use disorders. Established in 1990, Mid-ATTC is a part of the Virginia Commonwealth University Medical School. The Department and Mid-ATTC are engaged in several initiatives, supported by a co-located staff position responsible for human resource development.

Virginia Institute for Professional Addiction Counselor Training (VIPACT) - Originally a joint venture with the State of Maryland in the 1980s, VIPACT is an established curriculum that trains entry level counselors to prepare them for the substance abuse certification examination offered by the Board of Counselors in the Department of Health Professions. The classes are provided at no cost to CSB employees or employees of agencies providing contractual services to CSBs. Working under the auspices of an interagency agreement with the Department, Mid-ATTC staff revised the curriculum in 2002 to reflect evidence-based counselor competencies. Instructors are experienced practitioners specifically selected for their expertise in training and educating. Participants have included entry-level workers currently employed in community substance abuse treatment programs, nurses employed in state hospitals, and master’s level mental health professionals seeking knowledge and skills to address the needs of individuals with co-occurring mental health and substance use disorders.

Virginia Summer Institute for Addiction Studies (VSIAS) - Every summer, the Department joins with a number of other state agencies and organizations, including the College of William and Mary, Mid-ATTC, the Virginia Association of Alcoholism and Drug Abuse Counselors, the Virginia Association of Drug and Alcohol Programs, the Substance Abuse Certification Alliance of Virginia, the Substance Abuse and Addiction Recovery Alliance, the Departments of Corrections and Criminal Justice Services, and the Virginia Association of Community Service Boards Substance Abuse Council to host a five day residential training event at the College of

William and Mary that provides conferees with lectures from nationally known experts in the treatment and prevention of substance use disorders. Topics range from basic knowledge to advanced training, including a for credit graduate level course. The third annual weeklong event was held July 18-22, 2005, and was attended by nearly 800 professionals.

Co-Occurring Disorders – In 2004, the Department received a three-year grant from the federal Substance Abuse and Mental Health Services Administration to improve the infrastructure necessary to access treatment for individuals with co-occurring substance use disorders and mental illness. A portion of this funding supports ongoing training provided by Dr. Kenneth Minkoff, a leading expert in the field. Eleven CSBs are directly involved in this project and the Department is exploring other venues to provide training for mental health and substance abuse professionals. Department and Mid-ATTC staffs have participated in training provided by the federal Co-Occurring Center of Excellence and these experiences are providing a foundation on which to develop further technology transfer in the services system.

Prevention Training – Prevention has evolved into a science-based service and specific training in prevention theory and practice for CSB prevention management and staff is necessary for the implementation of effective prevention services in communities. Prevention training focuses on areas such as conducting community risk assessments, developing community service plans that include all domains and people in the community, and implementing and evaluating evidenced-based prevention programs and activities. As very few universities provide specific training in prevention science and practice, prevention training and information must be made available from a variety of sources to reach and strengthen the CSB prevention workforce.

Behavioral Support Training: Many direct care workers employed by MR Waiver providers, as well as many new providers, do not have experience or training in how to work with the population served, particularly those with behavioral challenges resulting from co-occurring mental illness or autism. Best practice models of positive behavioral support are available, however training resources have been limited to Medicaid regulations for the past several years. On August 1, 2005, the Department implemented a yearlong, Internet web-based training program, College of Direct Support, for staff serving people with disabilities to enhance the general training for direct care staff and providers.

Goals, Objectives, and Action Steps

Goal 35: Partner with public and private organizations and providers to address systemic issues in recruiting and retaining an adequate workforce within the mental health, mental retardation, and substance abuse services system.

Objectives:

- 1. Provide opportunities for services system partners to actively participate in system-wide workforce initiatives and build partnerships for effective collaboration and consensus on workforce issues and initiatives and programs.**

Action Steps:

- Continue to partner with system stakeholders to address workforce issues and initiatives.
- In collaboration with the Workforce Steering Committee, address system-wide workforce issues, support system-wide changes emerging from survey results and outcomes of Workforce Steering Committee subcommittee reports, and prioritize initiatives for system-wide changes.
- Share information and data with system stakeholders in order to address internal workforce issues and challenges.

- d. In collaboration with system-wide partners, include workforce initiatives in conferences and other educational forums.

2. *Implement strategies to enhance recruitment and retention of critical positions.*

Action Steps:

- a. Partner with universities to obtain graduate students to assist in the development of a marketing and communications plan and a public education campaign for the recruitment and retention of critical positions.
- b. Work with primary, secondary, and technical schools and institutions of higher education to educate their students about the services system and potential career opportunities.
- c. Develop a system-wide recognition awards program for the mental health, mental retardation, and substance abuse services system's workforce.
- d. Develop techniques to recruit and retain critical positions via toll-free call center, space advertisements, TV and radio public service announcements, an interactive web site, web promotion, brochures, posters, direct mail campaigns, employee referral cards, bumper stickers, newspaper articles and profiles, radio interviews, forums, exhibits, and outreach programs.

3. *Implement a system of workforce planning for the Department in order to accurately project workforce needs and resources.*

Action Steps:

- a. Complete development of a comprehensive workforce plan that is linked to the Department's strategic plan and consistent with the requirements of the Virginia Department of Human Resource Management.
- b. Use the workforce database to gather and analyze demographic workforce indicators for the plan.
- c. Monitor the implementation of and update the comprehensive workforce plan.

Goal 36: Assure that the mental health, mental retardation, and substance abuse services system workforce is competent and well trained to provide quality services and supports.

Objectives:

1. *Create partnerships with Virginia universities, colleges, community colleges, and other learning organizations to expand the numbers and skill levels of hard-to-fill professional and direct care positions.*

Action Steps:

- a. Establish and support implementation of a developmental career path for state facility Direct Service Associates.
- b. Support scholarships and other incentives to increase the number of students entering training and academic programs for difficult-to-fill professional and direct care positions.
- c. Assist current and future staff obtain scholarships and educational or financial aid.
- d. Explore potential academic partnerships to support on-site-training of graduate, undergraduate, and medical students at state facilities and CSBs
- e. Implement nursing and direct care professional distance-learning techniques on a statewide basis.
- f. Continue to evaluate, in collaboration with educational institutions, distance-learning programs for efficiency and effectiveness on a statewide basis.

- g. Maintain and enhance the Department's Workforce Development and Innovation Web Site as a resource for services system partners.

2. *Increase the skills and productivity of professional, paraprofessional, and administrative support staff through distance learning, regional and statewide training programs, conferences, and other learning opportunities.*

Action Steps:

- a. Develop and implement DSA, CNA, LPN, and RN on-site educational programs that support career ladder progression for future and current nursing professionals.
- b. Develop and implement on-site educational programs that support career ladder progression for direct care professionals.
- c. Evaluate and obtain continuing education programs for critical positions by partnering with the community college system to offer continuing education credits or certificates.
- d. Implement training and cross-training programs designed to develop provider skills necessary to meet the needs of the most challenging individuals, including individuals with co-occurring disorders and the gero-psychiatric population
- e. Promote cross training of nursing home staff to address the needs of individuals who are at risk of institutional placement due to psychiatric or behavioral needs.
- f. Explore the feasibility of establishing a certificate and associate degree program sequence for staff.
- g. Evaluate and implement incentives such as certificates, pay differentials, and other methods of recognition for direct care workers who obtain in additional training.
- h. Provide high performance organization leadership training to Department central office and state facility staff through a public academic partnership with the University of Virginia
- i. Enroll a wide variety of providers in the College of Direct Support training to provide opportunities for increasing direct care staff skills by using a web-based training program.
- j. Revise the MR Waiver Workbook to include information on positive approaches to supporting people with mental retardation and co-occurring MR/MI.
- k. Develop more certified professional in the area of behavioral consultation by combining workforce efforts with the Positive Behavioral Support project.

3. *Increase the basic knowledge and skill level about substance use disorders and evidence-based practices of current professionals and expose younger professionals to the field of treatment for substance use disorders.*

Action Steps:

- a. Continue to implement the Virginia Institute for Professional Addiction Counselor Training, revising the curriculum as needed.
- b. Continue to implement the Virginia Summer Institute for Addiction Studies and support participation by CSBs and their contract agencies.
- c. Continue to sponsor regional or onsite training offerings and seek other opportunities to enhance knowledge and skill in implementing evidence-based practices.
- d. Continue to collaborate with the Mid-Atlantic Addiction Technology Transfer Center.
- e. Continue to respond to developing trends and issues by sponsoring workshops and training events.
- f. Continue to collaborate with other states and other state agencies to provide training.

4. *Increase the number of training, support, and skill-building opportunities available to CSB prevention directors and staff on evidence-based prevention services that address prioritized risk factors and un-served populations.*

Action Steps:

- a. Expand the dissemination of prevention science and program information and materials by the Regional Alcohol and Drug Abuse Resource Center.
- b. Provide orientation and mentoring for new prevention directors and staff in prevention science and the prevention database.
- c. Continue to provide scholarships for experienced prevention directors applying for prevention certification.
- d. Provide training and technical assistance to CSB staff and other prevention professionals in community-based prevention planning, collaboration, and universal and selective evidence-based prevention programs, program development, and evaluation through the Virginia Summer Institute for Addiction Studies.
- e. Continue the development and expansion of technology capacity through training and technical support to CSBs in the use of the prevention data system.

G. Service Quality and Accountability

Oversight and Accountability Activities and Challenges

As Virginia's system of public mental health, mental retardation, and substance abuse services is restructured, the Department must take affirmative steps to ensure that individuals being served receive quality services that are effective and appropriate for their individual needs. To achieve this, the Department emphasizes a variety of quality improvement and oversight activities, including protecting the human rights of individuals receiving services in state facilities and community programs, implementing a "zero tolerance" abuse and neglect policy in state facilities, defining and supporting the implementation of clinical best practices, establishing uniform clinical and administrative guidelines, licensing services, and monitoring the quality and performance of community and state facility services.

Licensing Services Providers: By Code, the Department is required to license providers that offer services to individuals with mental illness, mental retardation or substance use disorders, developmental disability waiver services, and residential brain injury services. The Department licenses all new services, renews licenses, conducts annual unannounced inspections, investigates all complaints in licensed services, reviews reports of serious injuries and deaths, and initiates negative action, including sanctions and revocations, against providers. The Department enforces regulations that promote the health and safety of individuals receiving the services and the surrounding community. These regulations include provider responsibilities for preparing for and responding to emergencies and disasters. The Department ensures that applicants who become licensed meet and maintain adherence to these regulatory standards of health, safety, service provision, and individual rights. Additionally, in an effort to increase efficiency, the Department is planning to establish a centralized call center for human rights and licensing complaints.

The current caseloads of the Department's licensing specialists are significantly higher than are the licensing caseloads of other agencies. Department licensing caseloads have grown each year as the number of providers of mental health, mental retardation, and substance abuse services has increased and new statutory requirements have been enacted to license providers of developmental disability waiver and brain injury services. In FY 2005 alone, the number of licensed providers increased by approximately seven percent. A joint legislative study of child and adult group homes may result in increased licensing demands in terms of monitoring, sanctions, and negative actions. Additional licensing specialist positions are needed to manage

current caseloads and address projected future growth in caseloads and increased oversight requirements.

Protection of Individual Human Rights: The *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services* (12 VAC 35-115-10 et seq.) became effective on November 21, 2001. These regulations replaced the three sets of human rights regulations for state facilities, community programs, and licensed private psychiatric hospitals that had been in effect for many years. These regulations explain and expand upon the fundamental rights of individuals receiving mental health, mental retardation, and substance abuse services described in § 37.2-400 of the *Code of Virginia*. The regulations recognize that individuals receiving services have a right to full participation in decision-making and clinically appropriate treatment. These regulations also define the composition, role, and functions of the Department's human rights system, including Local Human Rights Committees (LHRCs) and the State Human Rights Committee (SHRC). They establish time frames and clear procedures for resolving individual complaints.

In January 2005, the Department completed its periodic review of the existing human rights regulations in accordance with the Governor's Executive Order 21. This review concluded that the regulations needed to be updated to assure consistency with changes in state and federal laws and regulations. The Department convened a group comprised of individuals, family members, advocates, public and private providers, and SHRC and LHRC members to assist in revising the regulations. Proposed amendments to these regulations have been drafted and submitted for public review in accordance with the Virginia Administrative Process Act.

The Department makes advocacy services available to approximately 190,000 individuals receiving services from state facilities, all services licensed by the Department, and all services funded by the Department. The Department assisted with or monitored the investigations of 2,259 allegations of abuse and neglect and 1,314 human rights complaints in 2004. The Department also monitors all providers for compliance with 12 VAC 35-115, et seq., and provides consultation, training, and assistance to over 400 volunteer members of the 65 LHRCs.

A study completed in response to Item 323 of the FY 2000 Appropriation Act concluded the Department's human rights advocacy system was operating well beyond its capacity. This situation has not improved. With the increasing emphasis on community-based care and the corresponding expansion in the number of licensed providers and services, new demands have been placed on the Department to assure that the rights of individuals are protected. Human rights advocates will continue to experience increasing demands for consultation to and monitoring of human rights protections in new services. Because current LHRCs are at capacity across the state, the continuing growth in the number of licensed providers will result in the need to recruit, develop, and train new local human rights committees. Investigations of allegations of abuse and neglect and human rights complaints also will increase due to growth in the numbers of new providers and services.

Investigations of Allegations of Abuse and Neglect: The Department has established a "zero tolerance" policy with regard to abuse and neglect allegations in state facilities. To implement this policy, the Department established an Abuse/Neglect Investigations Unit in 2000. Working closely with Department human rights and personnel staff, the unit works to ensure that state facilities protect individual safety and adhere to Human Rights Regulations requirements related to abuse and neglect. The unit has trained and certified around 70 investigators throughout the state facility system and has processed approximately 3,000 allegations since its inception.

Reduction in the Use of Seclusion and Behavioral Restraint: The provision of non-coercive treatment and care in state hospitals, including the reduction and elimination in the use of

seclusion, restraint, and time-out, continues to be a priority of the Department and a focal point for the Office of the Inspector General. The Department has implemented Therapeutic Options of Virginia (TOVA), a behavior interaction-training program developed to meet the specific needs of staff that work with individuals with mental illnesses or mental retardation. This training program is distinguished by its focus on improving therapeutic communications between individuals and treatment providers. It uses the principles of applied behavior analysis and psychosocial rehabilitation to train caregivers to more appropriately interact with individuals in a manner that supports the therapeutic interventions of the treatment team. During the past two years, all state facility staff were trained to use the new techniques. The training program is now also available at a reduced cost to CSBs, private providers, and other state and private entities through a special contractual agreement with Therapeutic Options, Inc.®.

During the next biennium, the Department's seclusion, restraint, and time-out reduction efforts will be focused on: (i) revising the Human Rights Regulations relative to restrictive procedures to reflect the values of choice and self-determination; (ii) providing training to community and state facility staff on recovery-oriented treatment services designed to reduce the use of restrictive procedures; and (iii) offering training and consultation services related to positive behavioral supports and behavioral treatment approaches to community and state facility services providers. In response to recommendations made by the Office of the Inspector General, these activities will focus initially on community and inpatient providers who serve individuals with mental retardation.

Improving Treatment Services: The Department has developed preliminary plans to offer a conference that will focus on operational strategies for transforming services systems. This training will demonstrate how providers can implement the Department's vision of an individual and family-centered system of care that supports recovery, self-determination, and empowerment. The conference will also train individuals and family members on proven strategies for choice and self-determination. The conference will draw upon the experiences and expertise of individuals, family members, and local providers and will feature national experts who have successfully implemented the values of a transformed system of care. Conference workshops will include evidence-based practices as a necessary step for quality care and recovery; changing the organization's treatment culture to support self-determination and choice; developing and managing peer-operated programs and services; and developing funding strategies to support implementation of evidence-based practices.

Evaluation of Treatment and Services: The Department has, for many years, submitted data to the NASMHPD Research Institute for state facilities that are accredited under Joint Commission on Accreditation of Health Care Organizations (JCAHO) Hospital Accreditation Standards. During the last biennium, the Department began to automate the data collection process and most data is now extracted from existing databases. Automation of this process will create allow the Department to construct a quality management data warehouse that can be used to evaluate risk, quality, and outcomes at the individual or state facility level. When completed, this warehouse will allow staff to access data for operational research and reporting to the Department's Clinical Services Quality Management Committee (CSQMC) and other internal and external quality and risk-related reporting requirements.

Guardianship: The Department estimates that over 3,000 individuals across Virginia require a guardian or other type of substitute decision-maker in order to facilitate their transition from state facility to community services or to enable them to receive services for which consent is required in community programs. When no substitute decision-maker is available, state facilities and community providers can access the judicial system for court ordered treatment. This alternative provides the required authority for needed treatment, but it does not provide for the participation in decision-making that is necessary for individuals who lack the capacity to participate in other aspects of their care. Court ordered treatment also does not provide for

individual choice. When no family member is available to serve as an authorized representative, the state facility or community provider must absorb the cost incurred by pursuing the appointment of a guardian. The average fee for each guardianship proceeding and appointment is \$2,000 per year.

Compliance with State Facility Active Treatment and Habilitation Clinical Care

Expectations: The Department continues to meet established Department of Justice (DOJ) plans to improve the care of individuals served in state facilities. Key requirements of these continuous improvement plans include:

- Increased ratios of staff to individuals receiving services;
- Enhanced staff training;
- Enhanced structure and provision for medical care;
- Increased individualized active treatment with individual involvement in treatment planning;
- Structured and coordinated planning for discharge and placement in the most integrated setting; and
- Focused efforts to protect individual rights, safety, and well being, especially related to the use of seclusion and restraint.

Today, all state facilities self-monitor and work with central office staff to assure that continuous facility improvement plans are successfully implemented and maintained. Central office staff also works with the state facilities to address and monitor facility-specific improvement plans that respond to findings of external consultants, Department internal audits, the Office of the Inspector General (OIG), and the Virginia Office of Protection and Advocacy (VOPA).

Created by legislation in 1999, the OIG inspects, monitors, and reviews the quality of services provided in state facilities and in licensed providers that include CSBs, private providers, and Department of Corrections mental health units. The OIG conducts announced and unannounced inspections and investigations that result in findings and recommendations to the provider. The OIG reports all findings, recommendations, and progress made toward implementing recommendations to the Governor and General Assembly.

In 2004, the OIG initiated systemic reviews of training centers and state hospitals. Key domains used to inspect and evaluate state facility performance included the facility missions and values, individual access and admission, service provision and individual activities, facility operations related to individual and staff safety, facility operations related to living environments, staffing patterns, system performance, and community relationships. The resulting OIG reports included system-wide and state facility specific recommendations for change.

Adherence to State Facility Clinical Guidelines: In FY 1999, the Department launched a major project to develop consistent and uniform clinical guidelines and operating procedures to promote and support clinical practice. These guidelines and procedures are based on and guided by the clinical skills and experience of state facility professionals and expert consultants, the best currently available clinical evidence, the experiences of other public and private providers, and state and federal regulatory and certification requirements. A key aspect of this improvement effort involves monitoring the performance and effectiveness of clinical guidelines and operating procedures to assess whether the processes have produced the desired result or require redesign and if there are opportunities to further improve them.

Performance data, reflecting a wide range of clinical and operational activities, are being collected through the Department's Data Dashboard, the Seclusion and Restraint Database, the QS1 Pharmacy Database, Annual Facility Quality Management Reports, and the MedIs Medication Reporting System, all of which are used to identify service delivery trends and determine the need for new clinical guidelines and operating procedures. Ongoing evaluation of

the effectiveness of existing procedures processes is a cooperative effort involving the Department's central office and state facility quality managers, health information managers, training directors, and staff responsible for collecting or tracking clinical and regulatory data.

Management of Potential Risks and Liabilities in State Facilities: Department and state facility leadership and staff must proactively address risks and liabilities inherent in ongoing programs and daily operations. Management of risks and liabilities continues to take on new dimensions, including implementation of federal regulations governing the privacy and security of patient identifiable information under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA), which took effect in April 2003. In addition, §51.5-37.1 of the *Code of Virginia* requires the Department to report all deaths and critical incidents to the Virginia Office for Protection and Advocacy (VOPA) within 48 hours of occurrence or discovery and provides follow-up reports of then known facts. A VOPA Incident Tracking System database has been established in the central office to assure implementation, monitoring, and documentation of compliance with this requirement.

Quality Management Review Activities: In the summer of 2005, the *Patient Safety and Quality Improvement Act* was signed by the President to promote cultures of safety across health care settings. This act establishes federal protections that encourage thorough, candid examinations of the causes of health care errors and the development of effective solutions to prevent their recurrence. The legislation grew out of claims by the Institute for Medicine and JACHO that existing health care practices drove errors underground because caregivers did not feel safe to report errors and, therefore, could not collectively learn from their mistakes. The Department has initiated a Just Culture Program that embraces state facilities as learning environments and state facility staff as teachers and promoters of patient safety and quality improvement. Through this program, the Department will implement the Risk Management and Patient Safety Institute's critical steps, which include: acceptance that a blaming approach will not prevent error, open discussion about errors and near misses, system-wide allowance for mistakes to occur, acceptance of the possibility of failure, and acknowledgement that errors may be expected and the workforce must be trained to identify and recover from errors.

Peer review is a privilege afforded physicians under the *Health Care Quality Improvement Act of 1986* and by state laws governing peer review activities. It is critical that such a privilege be guided by a set of clear rules and requirements. To this end, the Department has developed policies and procedures to formalize its quality management processes, to protect the confidentiality of individuals receiving state facility services and physicians, to ensure the appropriate use of peer review information, and to distinguish this review from other administrative and operational review mechanisms. Additionally, the Department's central Clinical Services Quality Management Committee (CSQMC) reviews the appropriateness, effectiveness, and overall quality of care in state facilities. This review is an important tool that allows the Department's leadership to continuously evaluate and improve quality of care through individual case reviews, assessment of physician practice patterns, and evaluation of systems and processes that support medical and clinical practice.

Service Delivery and Utilization Management

Utilization management (UM) programs use established, industry-accepted standardized processes to conduct a review of the need (utilization review) and the best use of available mental health resources (utilization management) before or during a period of service. A comprehensive and system-wide public UM program does not currently exist for reviewing the best use of services provided to persons with serious mental illnesses who have both acute and chronic care needs. Different UM methods are used by state hospitals, CSBs, and community hospitals and other healthcare providers that contract with CSBs or the Department for inpatient hospitalization and crisis stabilization services.

Implementation of a comprehensive UM system would require integration of multiple data sources and multiple providers and would necessitate automation on a system-wide level. The variety of service settings and the multiple service programs compound the difficulty in aggregating and comparing service use patterns. Implementing a UM infrastructure at the system level would focus on:

- Establishing clinical criteria compatible with the specific service level;
- Collecting these data and clinical profile data in a consistent manner
- Communicating these data to the interested services providers, such as regional partnership planning groups, regional investment projects, CSBs, state hospitals, and inpatient bed purchase contractors;
- Collecting data in clinical profiles for use in describing the characteristics of special needs populations.
- Benchmarking with other state and federal datasets; and
- Evaluating the efficiency and effectiveness of the public system to provide services using the characteristics of access, quality, and cost.

These data could then be used and managed by the state hospitals, CSBs, and in some instances a regional public mental health consortium such as the consortium established for the Region IV (Central Virginia) Acute Care Project. Potential outcomes include improved care and reduced cost by data-derived matching of severity of illness to treatment level. Data could also be used to inform clinical and administrative best practices. The Department would need additional resources to establish the data system required to capture and report these data.

Medications Tracking: Pharmaceuticals represent an ever-increasing percentage of health care budgets in Virginia and nationally. Knowledge of individual practitioner and system wide prescribing activity is essential for cost effective and high quality delivery of mental health medications. The Department developed and distributed a reference, *The Formulary and Pocket Guide to Psychopharmacology*, to clinicians nationally and to Virginia community and state facility programs. This guide provides information about the clinical indications and costs of various psychotropic medications.

The Department is developing a software system, MedIs, (Medication Information Systems), to extract and assemble data from state facility pharmacies and the Community Services Pharmacy. MedIs will increase understanding of medication usage by the entire system, by individual state facilities, by types of services within state facilities, and by individual practitioners. MedIs will capture and organize data for studying prescribing patterns, making comparisons, and identifying outliers. These data can be matched with indicators of clinical progress to determine the impact and efficacy of specific medications. MedIs also will track medication costs and allow the Department and state facilities to better plan medication budgets and manage medication expenditures.

Goals, Objectives, and Action Steps

Goal 37. Enhance the Department's oversight of quality of care and protection of individuals receiving mental health, mental retardation, substance abuse, developmental disabilities, or brain injury services.

Objectives:

- 1. Increase the number of licensing inspections in residential settings.**

Action Steps:

- a. Monitor the frequency of residential inspections.

- b. Review all licenses within six months of expiration.
- c. Identify work assignment strategies to ensure residential inspections are made and licenses are issued in response to workload demands, vacancies, and emergencies.
- c. Establish a centralized call center for human rights and licensing complaints.
- d. Seek funds to hire additional licensing staff.

Goal 38: Implement a high quality, effective, efficient, and responsive human rights system that protect the rights of each individual receiving services from providers of mental health, mental retardation, or substance abuse services.

Objectives:

1. *Increase the effectiveness and efficiency of the LHRC system.*

Action Steps:

- a. Identify specific aspects of the LHRC system and process that can be improved while maintaining the highest level of individual protections and reducing provider administrative burden.
- b. In collaboration with services system partners, revise the human rights regulations to implement recommended changes.

2. *Promote workable systems for rights protections by conducting fair, accurate, and consistent human rights monitoring activities across the state.*

Action Steps:

- a. Formalize the documentation and reporting of monitoring activities.
- b. Use a consistent monitoring tool for all monitoring activities.

3. *Increase the availability of human rights advocates to individuals in accordance with the recommendations in House Document No. 21 (2001); "Evaluating the Human Rights Advocates in State Facilities and Community Programs."*

Action Steps:

- a. Seek funding to increase by two the number of human rights advocates.

4. *Revise the existing human rights regulations to assure consistency with changes in state and federal laws and regulations.*

Action Steps:

- a. Adopt revised human rights regulations through the APA process.
- b. Implement the revised human rights regulations.
- c. Provide statewide training within 90 days of the promulgation of the revised regulations.

5. *Ensure that individuals who lack capacity to provide informed consent have uninterrupted access to appropriate treatment and services.*

Action Steps:

- a. Increase the number of guardians and other substitute decision-makers for individuals receiving services in state facilities and community programs.
- b. In collaboration with services system partners, pursue specific options for increasing the availability and training of individuals to serve as surrogate decision-makers.

Goal 39: Ensure that Department and state facility quality management review functions are implemented according to clearly articulated policies and procedures.

Objectives:

1. ***Implement structures and processes to protect privileged case referral, information review activities, data collection, external consultation, record keeping, and reporting.***

Action Steps:

- a. Develop procedures with state facilities for the confidential transfer of information between facility Quality Management programs and the CSQMC.
- b. Continue to safeguard and maintain the confidentiality of individual information and quality management review activities that are generated by the CSQMC.
- c. At least annually, provide for an independent review of the safeguards in place to protect individual information and the privileges granted to the CSQMC by the *Health Care Quality Improvement Act of 1986*.

2. ***Evaluate the effectiveness of uniform clinical guidelines and operational procedures as tools for improving the quality of state facility treatment, care, and clinical services.***

Action Steps:

- a. Provide the Clinical Services Quality Management Committee (CSQMC) with continuous feedback and data about the effectiveness of treatment, care, and clinical service requirements established by uniform clinical guidelines.
- b. Provide data about important aspects of care, serious events, and other information that reflect the process and outcomes of treatment, care, and clinical services to the CSQMC.
- c. Through the CSQMC, routinely evaluate the data to ascertain the effectiveness of uniform clinical guidelines and the need for revisions and to identify problems in service delivery that may require new uniform clinical guidelines.

2. ***Periodically evaluate the functions, activities, and effectiveness of the CSQMC, as they relate to clinical case review, leadership, and oversight of important aspects of quality care.***

Action Steps:

- a. Implement a standard process and clearly articulated, measurable criteria for review.
- b. Develop, in collaboration with state facility quality managers, an independent review process to evaluate the effectiveness of the CSQMC.
- c. Submit a written report of the results and recommendations for improvement to the Commissioner and the members of the CSQMC.

Goal 40: Assure that publicly funded services provided in state facilities and CSBs are based on sound research that assures the highest quality treatment and the best clinical outcomes for individuals.

Objectives:

1. ***Expand the capability of the Department to conduct research.***

Action Steps:

- a. Identify the critical issues related to services quality for potential research and develop a research agenda based on these issues.
- b. Use the Seclusion and Restraint Database to conduct research on effective strategies to manage volatile behavior among individuals in state facilities.
- c. Continue to develop the quality management data warehouse as a research tool for evaluating risk, quality, and outcomes.

Goal 41: Establish a system of Just Culture to promote quality patient safety and care.

Objectives:

- 1. Develop a state facility infrastructure to encourage reporting and review of errors.***

Action Steps:

- Establish criteria for Just Culture Program case review pathways.
- Generate support for the use of the Just Culture Program with the State Human Rights Committee, VOPA, OIG, individuals, and state facility and central office staff.
- Develop and implement training on the use of Just Culture Program case review pathways in individual facility case reviews.
- Measure effectiveness of the improvements in reduction of error rates.

Goal 42: Implement a comprehensive and system-wide approach to public mental health utilization management.

Objectives:

- 1. Develop a utilization management infrastructure for state hospitals and CSBs.***

Action Steps:

- Establish clinical criteria for specific levels of service utilization.
- Develop a proposal and cost-benefit analysis for an automated database that integrates multiple data sources and multiple providers.
- Generate support for the collection of utilization management data among providers through training, education, and the dissemination of relevant literature.

Goal 43: Improve the medication practices of physicians, pharmacists, and nurses who have a role in the medication management process in community and state facility services.

Objectives:

- 1. Expand the capabilities of the Medls system in state facility pharmacies and the Community Services Pharmacy***

Action Steps:

- Develop Medls software to include state facility pharmacy reports.
- Expand the reporting capabilities of Medls to include medication usage, medication history, and clinical outcomes for individuals at admission and discharge.
- Use Medls reports to assess prescribing practices of individual practitioners, treatment team decision-making, quality oversight processes, and medication costs.
- Evaluate the use of Medls reports for clinical and administrative decision-making.

- 2. Include automated components for clinical outcomes measures in the Medls system.***

Action Steps:

- Survey state facilities to instruments they use to measure outcomes and determine instruments that are used most frequently.
- Assess the feasibility of developing an automated system to score and evaluate outcomes and the cost of linking this data to the Medls pharmacy data system.
- Develop a proposal for a short-term, non-automated pilot project to evaluate the benefits of such software development, in terms of improving medication outcomes, cost savings, and user satisfaction with the results.

- d. Based on the results of the pilot, identify resource requirements and develop an implementation proposal.

Goal 44: Promote the use of non-coercive techniques and reduce the use of seclusion and behavioral restraint in state facilities and community services.

Objectives:

- 1. *Promote the concept of and training in treatment without coercion in state facilities and community services.***

Action Steps:

- a. Monitor provider use of seclusion and restraint.
- b. Identify needs for future training and advocacy regarding the use of seclusion and restraint.
- c. Support the statewide use of TOVA.

- 2. *Provide ongoing training and consultation for community and state facility providers to support a non-coercive therapeutic environment.***

Action Steps:

- a. Sponsor a conference for community and state facility staff focused on strategies for implementing the Department's vision of a system that supports recovery, empowerment and self-determination.
- b. Train state facilities, CSBs, private providers, and other agencies in therapeutic interactions designed to reduce the use of coercive techniques.
- c. Provide ongoing training to community and facility providers on the causes of volatile symptoms and alternative strategies for managing such behaviors.

- 3. *Continuously evaluate the utilization of restrictive procedures in state facilities and their effects on the health and safety of individuals and staff.***

Action Steps:

- a. Through the CSQMC, routinely review standardized seclusion and restraint data and evaluate the effectiveness of restraint reduction strategies and training programs.
- b. Use seclusion and restraint data to study the relationship between staffing strategies and the use of coercive techniques.
- c. Use MedIs and seclusion and restraint data to evaluate the role of specific medication-therapies in the treatment of psychiatric symptoms that may necessitate the use of seclusion and restraint.

VI. RESOURCE REQUIREMENTS

The Department has identified the following resource requirements to respond to critical issues facing Virginia's services system.

MR Services System Transformation Initiative – State general funds totaling \$89,966,700 in FY 2007 and \$103,073,000 in FY 2008 and non-general funds totaling \$69,548,900 in FY 2007 and \$74,548,000 in FY 2008 are required for community services and supports necessary to implement the MR Services and Supports by Level of Care Model. These funds will support guardianships for 3,000 individuals who require substitute decision makers, the flexible use of funds for community services for 200 persons who are not eligible for the MR waiver and 300 persons who are in nursing homes, family support services for 2,700 persons, training and mentoring activities aimed at increasing individual and family participation, increased MR waiver reimbursement rates for services and supports by a general 20 percent increase and targeted differentials for high cost areas, 400 new MR waiver slots, and start-up activities to support implementation of the new Medicaid slots. Included in these funds is \$64,548,900 in state general funds and non-general funds in each year of the biennium to increase MR waiver rates and \$5,000,000 in state general funds and non-general funds in FY 2007 and \$10,000,000 in state general funds and non-general funds in FY 2008 to increase MR waiver slots.

MH Services System Transformation Initiative – State general funds totaling \$32,621,500 in FY 2007 and \$35,450,000 in FY 2008 are required to implement a community mental health system transformation initiative. These funds will support the flexible use of funds for community infrastructure investment; implementation of the "Suicide Prevention Across the Life Span Plan for the Commonwealth;" discharge assistance funding to support appropriate community placements for civil and not guilty by reason of insanity individuals in state facilities who are ready for discharge; community services for children and youth including expansion of the system of care initiative, eight mental health detention center projects, and a statewide family support coalition; and community-based recovery support services such as respite, safe houses or in-home services, mobile outreach, walk-in crisis centers, 23-hour crisis programs, and peer-operated and peer provided services.

Unmet Community MR Services Needs – State general funds totaling \$10,298,400 in FY 2007 and \$21,214,700 in FY 2008 are required to support the provision of community day support and residential services for adults and adolescents or children on CSB waiting lists for those services. These funds would address the needs of half of those individuals during the biennium.

Early Intervention/Part C – State general funds totaling \$4,348,400 in FY 2007 and \$11,161,300 in FY 2008 are required to support the provision of Part C early intervention services for infants identified through the annual Part C child count as needing early intervention services, develop a public awareness program, and complete the data collection system to meet federal and legislative reporting requirements.

SA Services System Transformation Initiative – State general funds totaling \$22,107,000 in FY 2007 and \$25,543,300 in FY 2008 are needed to implement a substance abuse services system transformation initiative. These funds will support the flexible use of funds for an enhanced services treatment model for nearly 1,200 persons with opioid addictions in rural southwest Virginia; treatment services for individuals served by the Departments of Rehabilitative Services, Health, Corrections, and Juvenile Justice; evidence-based and best practices; state facility diversion and crisis stabilization services for persons with co-occurring substance use disorders and mental illness; residential or inpatient treatment programs for adolescents; perinatal residential treatment and services; enhanced Project LINK outpatient

services; Co-Occurring Services Integration Grant implementation; Strengthening Families community substance abuse prevention programs; and internal CSB program evaluation activities.

Direct Service Associate (DSA) Salary Alignment and Competency Development – State general funds totaling \$4,008,376 in FY 2007 and \$4,747,380 in FY 2008 are required to adjust the entry salary of state facility DSAs and to provide a developmental career path through which new DSAs would receive enhanced training and interested DSAs would learn skills necessary to perform higher level clinical and leadership tasks.

Unmet Community MH Services Needs – State general funds totaling \$7,434,300 in FY 2007 and \$15,314,600 in FY 2008 are required to support the provision of community day support and residential services for adults and adolescents or children on CSB waiting lists for those services. These funds would address the needs of half of those individuals during the biennium.

Unmet Community SA Services Needs – State general funds totaling \$1,090,400 in FY 2007 and \$2,246,300 in FY 2008 are required to support the provision of community day support and residential services for individuals on CSB waiting lists for those services. These funds would address the needs of half of those individuals during the biennium.

Inpatient Pharmacy – State general funds totaling \$4,344,996 in FY 2007 and \$5,055,679 in FY 2008 are required to maintain pharmacy operations in each state facility. These funds would offset increasing costs of pharmaceutical products and align the salaries of Hiram Davis Medical Center inpatient pharmacists to their peers in the state facility pharmacies.

Medication Management System Procurement – State general funds totaling \$4,410,844 in FY 2007 and \$611,474 in FY 2008 are required to implement a medications management system as the second phase of the Department's electronic health record. Funds would replace the current outdated pharmacy management system, implement a medication physician order entry system, and implement a bar coding system for medication administration.

Licensing Staff – State general funds totaling \$213,904 in FY 2007 and \$408,488 in FY 2008 and non-general funds totaling \$34,224 in FY 2007 and \$65,965 in FY 2008 are required to increase the number of Department licensing inspectors to 20. Two inspectors and a supervisor would be added in FY 2007 and three inspectors in FY 2008.

Central Office System Transformation Leadership – State general funds totaling \$1,264,841 in FY 2007 and \$1,496,311 in FY 2008 are required to fund central office and services system transformation efforts in collaboration with state and local agencies, state facilities, community services and supports providers, and advocacy organizations. Funds would support central office development and oversight of a statewide educational campaign and two centers of excellence focused on implementation of recovery and resilience principles and practices, individual and family training and empowerment, and cross-agency transformation activities.

State Facility Equipment Replacement – State general funds totaling \$7,668,387 in FY 2007 is required to replace outdated medical and specialized or adaptive equipment; living and work area furnishings; grounds, laundry, food service, and housekeeping equipment; and patient or resident and support transportation.

Community Services (Aftercare) Pharmacy – State general funds totaling \$2,107,877 in FY 2007 and \$3,858,691 in FY 2008 are required to offset increasing costs of pharmaceutical products and align the salaries of Community Services Pharmacy pharmacists to their peers in the state facility pharmacies.

Regional Support Centers – State general funds totaling \$500,000 in FY 2007 and FY 2008 are required to create regional support centers at Southeastern Virginia Training Center and Southside Virginia Training Center. These centers would provide specialized outpatient dental, behavioral consultation, and specialized clinical services such as nutrition management, occupational, physical, and speech therapy, audiology services, and rehabilitation engineering that are not currently available in the community. The centers also will help expand community capacity by training CSBs and other community providers and healthcare professionals on key topics identified as priority needs by regional stakeholders.

Behavioral Health Regional Health Information System (RHIO) Project – State general funds totaling \$400,000 in FY 2007 and FY 2008 are required to create a public-private behavioral health regional health information organization (RHIO) in far Southwest Virginia. The RHIO will allow area state facilities, CSBs, and private providers, with appropriate authorizations, to electronically share behavioral healthcare information. Funds will be used to support start-up costs to establish the project, development of an electronic health records in participating state facilities and CSBs, and infrastructure development.

Public Academic Partnerships – State general funds totaling \$448,600 in FY 2007 and FY 2008 are required to strengthen public academic partnerships to enhance service delivery and competencies of services system leadership. These funds would support agreements to implement a MCV fellowship program to improve behavioral health services to children and adolescents in underserved rural areas, to expand the Department's High Performance Organization leadership training and skill building program partnership with the University of Virginia, and to establish a Commonwealth Center for Mental Health Policy that builds on the Department's partnership with the University of Virginia Institute of Law, Psychiatry and Public Policy.

Human Rights Centralized Call Center and Staffing – State general funds totaling \$196,606 in FY 2007 and \$186,606 in FY 2008 are required to establish a centralized Call Center and support three additional positions to staff this center and to add one human rights advocate position for the Northern Virginia region.

Data Integration Project – State general funds totaling \$288,176 in FY 2007 and \$198,960 in FY 2008 are required to establish a framework of consistent automated applications that will meet current and future federal and state reporting requirements. Funds also will support the acquisition of current application development tools and provide appropriate staff training to utilize these tools.

Architecture and Engineering Staffing – State general funds totaling \$285,541 in FY 2007 and FY 2008 are required to add three positions with oversight responsibilities for state facility capital project, physical plant, maintenance, and food services and dietary operations.

VCBR Staff Salary Adjustment – State general funds totaling \$41,951 in FY 2007 and FY 2008 are required to align security positions at the Virginia Center for Behavioral Rehabilitation with comparable positions at state correctional facilities.

Special Olympics – State general funds totaling \$120,000 in FY 2007 and FY 2008 are required to support the Virginia Special Olympics program. This program provides year-round sports training and athletic competition in a variety of sports for persons with intellectual disabilities.

Summary of Current Resource Requirements Identified by the Department

Resource Requirement	FY 2007		FY 2008	
	SGF	NGF	SGF	NGF
Mental Retardation Services System Transformation	\$89,966,700	\$69,548,900	\$103,073,000	\$74,548,900
Mental Health Services System Transformation	\$32,621,500		\$35,450,000	
Unmet Community MR Services Needs	\$10,298,400		\$21,214,700	
Early Intervention/Part C	\$4,348,400		\$11,161,300	
Substance Abuse Services System Transformation	\$22,107,000		\$25,543,300	
Direct Service Associate Salary Alignment and Competency Development	\$4,008,376		\$4,747,378	
Unmet Community MH Services Needs	\$7,434,300		\$15,314,600	
Unmet Community SA Services Needs	\$1,090,400		\$2,246,300	
Inpatient Pharmacy	\$4,344,996		\$5,055,679	
Medication Management System Procurement	\$4,410,844		\$611,474	
Licensing Staff	\$213,904	\$34,224	\$408,488	\$65,965
Central Office System Transformation Leadership	\$1,264,841		\$1,496,311	
State Facility Equipment Replacement	\$7,668,387			
Community Services (Aftercare) Pharmacy	\$2,107,877		\$3,858,691	
Regional Support Centers	\$500,000		\$500,000	
Behavioral Health Regional Health Information System (RHIO) Project	\$400,000		\$400,000	
Public Academic Partnerships	\$448,600		\$448,600	
Human Rights Centralized Call Center and Staffing	\$196,606		\$186,606	
Data Integration Project	\$288,176		\$198,960	
Architecture and Engineering Staffing	\$285,541		\$285,541	
VCBR Staff Salary Adjustment	\$41,951		\$41,951	
Special Olympics	\$120,000		\$120,000	
TOTAL	\$194,201,027	\$69,583,124	\$232,428,844	\$74,614,864

Notes: Non-general funds include anticipated federal Medicaid and Title IV-E funds.

VII. CONCLUSION

This document responds to the requirement in §37.2-315 of the *Code of Virginia* for a six-year Comprehensive State Plan for mental health, mental retardation, and substance abuse services that identifies the services and supports needs of persons with mental illnesses, mental retardation, or substance use disorders across the Commonwealth; defines resource requirements; and proposes strategies to address these needs. The directions established in the *Comprehensive State Plan for 2006-2012* would enable the Commonwealth to accelerate the transformation of the public services system to a more completely community-based system of care while preserving the important roles and service responsibilities of state hospitals and training centers in Virginia's publicly funded services system.

Through the active involvement of hundreds of interested individuals and the work of seven Regional Restructuring Partnerships and five statewide Special Population Workgroups, the Department and its partners continue to emphasize transforming the publicly funded mental health, mental retardation, and substance abuse services system to fully implement a recovery and resilience-oriented and person-centered system of services and supports. This transformed system will promote self-determination, empowerment, health, and the highest level of individual participation in all aspects of community life, including work, school, family, and meaningful relationships.

The *Comprehensive State Plan for 2006-2012* continues the direction set forth in previous *Comprehensive State Plans* to increase community options and individual choice; support opportunities for individual and family member education, training, and participation; promote collaborative activities with other agencies and services systems and private sector development; improve services oversight and accountability; advance quality improvement and care coordination; and address system administrative and infrastructure issues.

The policy agenda for publicly funded mental health, mental retardation, and substance abuse services for the next biennium continues to focus, to the extent possible, on two key themes:

Sustaining the progress that has been achieved during the past four years in implementing the vision for the future mental health, mental retardation, and substance abuse services system, and

Investing in services capacity and infrastructure needed to address issues facing the services system.

Appendix A

Regional Partnership Planning and Special Populations Workgroup Recommendations

REGION 1 STRATEGIC PLAN – WESTERN VIRGINIA

Goal #1: Address the regional critical need for acute care psychiatric beds in the private sector.

1. Identify funding to allow for regional purchase of acute care services.
 - a. Target reinvestment funding sufficient to purchase short-term treatment for commitments when Western State Hospital is full.
 - b. Manage acute care regionally through an active utilization management committee in collaboration with private providers.
 - c. Work towards regional pilot projects where the goal is the diversion of all Western admissions.
 - d. Expand contracting ability for acute care services to facilities beyond the Health Planning Region.
 - e. Reserve admissions to Western State Hospital to individuals needing longer term care while ensuring sufficient resources at Western in order to provide acute care services for those who cannot be served in community settings.
2. Develop process for evaluating the quality of care provided by private providers receiving reinvestment funding.
 - a. Solicit input from private providers on the process for evaluating services.
 - b. Formulate committee of CSB quality managers to determine appropriateness, access, outcome and general satisfaction with care provided.

Goal #2: Develop a Crisis Stabilization Program to better address needs of individuals with co-occurring needs related to mental health and substance abuse.

1. Address the need for support for individuals with mental retardation who experience short term and extreme behavioral challenges.
 - a. Work with the new director at the Central Virginia Training Center to consider recommendations of a committee comprised of staff from Western State Hospital, Central Virginia Training Center, and Central Virginia Community Services.
 - b. Pilot a recommended program, which would establish a special intervention team to allow stabilization to occur in the home residence including consultation, temporary staff support, and follow up.
 - c. Establish a crisis stabilization unit at Central Virginia Training Center to provide intervention for individuals who cannot safely be maintained in their own home due to risk of harm to self or others.
2. Address the needs of individuals in crisis who require intensive services and avoid inappropriate hospitalization at Western State Hospital.
 - a. Utilize new regional State general funds to enhance existing service offerings at both New Hope and Boxwood treatment programs to improve capacity to accept more challenging referrals.
 - b. Target some regional funding to provide additional bed purchase capability specifically for SA issues and detox services to supplement funds in the existing SA diversion project.
 - c. Get consultation and additional staff training for New Hope and Boxwood to increase staff knowledge and expertise in the effective management and treatment of individuals with co-occurring disorders.
 - d. Explore other avenues of support including fee-generating capability of crisis stabilization services.
 - e. Have regional Utilization Management Team track consumers served through these activities collecting relevant data to evaluate outcomes.

Goal #3: Improve collaboration for regional children's services.

1. CSBs to serve as the sole entry point into publicly funded mental health care.

- a. CSB case managers must manage the cases of all children accessing public funds for mental health care.
 - b. Assessment of the suitability of outpatient care must be made by CSB staff prior to the implementation of any more intensive, publicly funded intervention.
 - c. Access to CCCA, including for 10-day evaluations, made available only to those deemed appropriate for that service by CSB staff, with justification for not using less intensive, community-based services provided.
2. Strengthen resources within the CSB to solidify its position as the children's mental health authority.
 - a. Legitimize the role of the CSB case manager for discharge planning of CCCA patients through service funding to enable adequate staffing and involvement in the planning process.
 - b. Develop consultative liaison, perhaps through video-conferencing, with CCCA to allow CSBs access to the expertise of child psychiatrists, both for cases shared by CCCA and the CSB as well as for cases being maintained and receiving continuing care in the community.
 - c. Improve understanding of community resources and of the factors affecting transition from adolescent to adult services, such as access to entitlements, by providing training to CCCA staff in the community.

Goal #4: Provide services and supports outside of traditional catchment area boundaries.

1. Provide a PACT team for every CSB currently without such team.
 - a. Allocate funding to new teams which will be comprised of case management, residential support and psychiatric nursing staff with specific caseloads targeted to support stable community placement.
 - b. These teams will support many of the individuals identified in priority DAP plans for FY 05.
 - c. These collaborations will focus resources on improving responsiveness to individuals whose needs include case management, medications management, day rehabilitation, transportation and housing.

Goal #5: Replace Boxwood facility.

1. Using a previously completed feasibility report, prepare a financial analysis for debt service to construct a replacement facility using designs already completed.
 - a. Survey participating CSBs to assess willingness to increase per diem payments to service long term debt.
 - b. Present feasibility study and financial analysis to potential financing sources.
 - c. Secure financing and adopt appropriate borrowing resolutions from local governments of the RRCSB.
 - d. Complete architectural development and bidding.
 - e. List existing Boxwood property for sale.
 - f. Begin construction for replacement facility.

Regional Partnership Recommendations for State-Level Action:

1. Statewide Medicaid rates for core CSB services need to be evaluated and raised to be more reflective of the actual cost of providing services.
2. State funding needs to address the needs of individuals who do not qualify for Medicaid.
3. Pharmaceuticals represent an ever-increasing percentage of health care budgets in Health Planning Region I. The rising cost of medications must be addressed.
4. Legislation should be pursued to address needed training and education for sheriffs and magistrates regarding individuals with Temporary Detention Orders, etc.
5. Re-evaluate the current regional make-up in light of marked changes in population, demographics, and urban/rural balance over the past 25 years.

REGION 2 STRATEGIC PLAN – NORTHERN VIRGINIA

Strategic Direction for Mental Health Services:

1. Increase mental health community-based services to prevent psychiatric hospitalization or criminal diversion, whenever possible.

2. Increase mental health community-based services to discharge hospitalized patients when they are ready for community services.
3. Maintain the level and quality of inpatient services currently available to residents until better data on future demand is available.
4. Implement recovery principles throughout the mental health service system.
5. Provide readily available services.

Regional Work Group Next Steps:

1. Establish a regional work group to deal with the concerns of children and youth who have serious emotional disturbance.
2. Move recovery principles into practice.
3. Review options to meet the demand for inpatient care, including:
 - a. Diversion of consumers to community programs,
 - b. Use of public and private beds for TDOs,
 - c. Need to re-bid contracts,
 - d. Continuity of care for patients discharged from private hospitals into the care of CSBs,
 - e. Need for additional community-based resources, and
 - f. Increasing psychiatric bed capacity.
4. Publish a workbook for all potential and current NGRI patients to explain the NGRI system, patient rights and their recourses.
5. Develop an informational brochure to aid awareness of dual diagnosis (MR/MI).
6. Establish a regional work group to deal with the concerns of older adults with mental illness.
7. Continue to explore ways to work together more efficiently in areas of training, administrative processes and information technology on behalf of Northern Virginia programs.

Regional Partnership Recommendations for State-Level Action:

1. Improve Virginia's Medicaid Assistance Plan by:
 - a. increasing eligibility level from 80% to 100% of federal poverty level
 - b. setting rates at a level sufficient to cover costs of all Medicaid services
 - c. expanding the array of services, e.g., PACT as a bundled service.
2. Fully fund the entire continuum of care, including state facilities, private hospitals and community-based services.
3. Foster greater use of private sector providers by ensuring that they are reimbursed adequately by all sources, including public payers such as Medicaid and DMHMRSAS as well as private insurance companies.
4. Maintain an adequate capacity of psychiatric inpatient beds and community-based services.
5. Begin funding the recommendations contained in "One Community," the final report of the Olmstead Task Force.
6. Maintain the current bed capacity at NVMHI in light of increasing population and proposed reductions in the number of beds in the private sector.
7. Establish a Center for Excellence at NVMHI focused initially on sharing the approaches that have led to significant reductions in seclusion and restraint.
8. Re-bid the State contract for inpatient psychiatric care to include the option of pre-purchasing beds.
9. Actively promote the Recovery Principles throughout the Commonwealth.
10. Reestablish an Office of Consumer and Family Affairs in DMHMRSAS.
11. Establish and fund consumer empowerment training throughout the Commonwealth.
12. Request that the State design and implement, in collaboration with the private sector, a system for properly

addressing the growing need for services for older adults with mental illness and persons with dementia who have psychiatric symptoms.

13. Request that DMHMRSAS carefully consider the recommendations from the regional work groups studying how to better serve persons with a dual diagnosis of mental illness and mental retardation.
14. Coordinate regional and state service issues.
15. Fully fund medications provided through the State Aftercare Pharmacy for discharged state hospital and non-hospitalized consumers
16. Identify educational materials needed for General Assembly.
17. Implement consumer participation in policy and program levels.

REGION 3 STRATEGIC PLAN – FAR SOUTHWEST VIRGINIA

1. Increase community-based services.
 - a. Effective utilization of FY 05-06 funds for expanded services; DAP, PACT MR Waivers, etc.
 - b. Continue advocacy for funding to expand CSB/BHS infrastructure.
2. Reduce utilization of SWVMHI.
 - a. Initiation of Inpatient POS project is targeted to maintain more predictable acute admissions.
 - b. Region's dependency on SWVMHI prohibits bed closures at this time, will focus efforts on census reduction.
 - c. Long range goal of bed closures within 5 years IF Inpatient POS projects are adequately funded and there are no reductions in private psychiatric beds.
3. Provide acute psychiatric treatment through inpatient POS projects to treat consumers closer to home and facilitate multi-system partnering for local psychiatric care.
4. Expand DAP plans for FY 05-06 to reduce Institute utilization, expand community-based resources and promote positive outcomes for SPMI consumers identified for these services.
 - a. Free up admission beds now tied up by consumers waiting for ERS beds.
 - b. Implement approximately 14 DAP plans.
5. Form a second PACT program in the region to effectively utilize state funds for a dynamic community based intervention.
 - a. Improve treatment outcomes, maintain placement in community, reduce utilization of inpatient services, increase participation in recovery/treatment plans and address co-morbid issues that complicate treatment
 - b. Serve 75 SPMI consumers in the Mt Rogers CSB catchment area.
6. Secure MR Waiver Slots for those consumers on the Community Urgent Waiting lists.
7. Access facility-based MR Waiver slots for MR consumers in SWVTC and SWVMHI.
8. Increase public education/awareness of mental health, mental retardation and substance abuse issues.
 - a. Implement public education MR/MI program, "Pathways", which targets both the public and increases direct care staff awareness.
 - b. Partner with consumers and family members in MH awareness efforts such as "Consumer & Family Involvement Project".
9. Continue consumer and family involvement in strategic planning and decision making for the region.
 - a. Include stakeholders as voting members of the Southwest VA Behavioral Health Board's to demonstrate the Region's commitment to community involvement.

Regional Partnership Recommendations for State-Level Action:

1. Previous proposed legislation to raise the income level for Medicaid eligibility must be passed to expand coverage for uninsured consumers.

2. State agencies actively pursue grant opportunities to increase health services for rural Virginians, seeking to partner with local public and private entities in accessing possible grant funding.
3. Substance Abuse Services should be adequately funded to address the overwhelming numbers of dually diagnosed consumers and provide detoxification services in settings other than acute psychiatric facilities. The SA Medicaid initiative must be funded by the General Assembly for community based SA services development.
4. Dental Services for consumers is a vast unmet need and should be addressed as the public health issue that it is. Medicaid should cover dental care.
5. Virginia DOH & DMHMRSAS coordinate efforts to recruit board certified physicians (psychiatrists) and licensed mental health professionals for rural Virginians.
6. DMHMRSAS partners with CSB/BHS and State facilities to advocate for legislative action to replicate evidence based practices such as mental health courts to increase services for consumers in the correctional system that need MH/MR/SA supports or services.

REGION 4 STRATEGIC PLAN – CENTRAL VIRGINIA

Goal #1: Implement a Region IV/SVTC Project.

1. Implement a Region IV/SVTC Emergency Bed Project for persons with mental retardation.
 - a. Maintain two permanent “reserved” emergency beds (one male and one female) at SVTC on the Behavioral Unit to provide intensive services when other local behavioral efforts have not worked
 - b. Regionally manage admissions from and discharges from these emergency beds
 - c. Regionally pool several Waiver slots to guarantee that individuals will be able to be discharged when an appropriate community bed is located.
2. Establish a Region IV Emergency Residential Program in an empty on-grounds cottage at SVTC so individuals can be moved from their community residence for a short time to address behavioral challenges.
 - a. Through each CSB, provide 24 hour staffing and transportation and expenses.
 - b. Through SVTC, provide limited staff support from its behavioral, clinical, and medical staff.
 - c. Obtain DMAS/DMHMRSAS assignment of 4 new MR Facility Waiver slots to support this project.
3. Train local staff and family members to work with individuals when they return home.
4. Provide funding for respite care in facilities such as Camp Baker as a “step down” from these projects.

Goal #2: Review Clinical Program Design and Mission of Regional SA Services Operated at Turning Point.

1. Establish a regional clinical review workgroup to evaluate service populations and clinical programming at Turning Point and maintain SAPT Block Grant Funding.
2. Develop regional wrap-around services for opiate addiction.
3. Develop flexible regional purchasing agreements.

Goal #3: Develop self-contained SA treatment in jails

1. Establish a six-week Intensive Addictions Focus program based on the Henrico County jail's social learning recovery model programs in three jails identified by Region IV Reinvestment Jail Team. In each facility:
 - a. Dedicate one entire living area (dayroom, POD) in each participating facility for inmates who volunteer to participate in a self-help recovery program.
 - b. Receive program description, schedule of activities, and list of resource materials from the Henrico County Sheriff's Department and Henrico CSB.
 - c. Temporarily transfer a small group of inmates who demonstrate a strong interest in the program to the Henrico County Jail to complete the Intensive Addictions Focus program and return to their facilities to provide leadership as senior members of the new program.
 - d. Arrange for the Henrico County Jail and Henrico CSB staff to provide consultation to the project's clinical staff.

Goal #4: Study alternatives to inpatient care for adults and/or children.

1. Examine the feasibility of establishing sub acute crisis stabilization and supervised residential services for children and adults.
 - a. Explore the need for statutory or regulatory changes that would provide for or allow locked or otherwise controlled residential facilities.

Goal #5: Establish ways to enhance private/public coordination of care.

1. Formalize service access structure and communication processes to provide collaboration that is necessary to ensure that bureaucratic systems do not impede access to appropriate services.

Regional Partnership Recommendations for State-Level Action:

1. The Regional Strategic Planning Partnership adopted a goal of prioritizing population groups and working toward uniform service availability across jurisdictions. Region IV proposes to use additional regional and local funding to move in this direction.
2. Certain benefits and services should be universal. When and if additional resources become available, a second level of services could be implemented. A third level of services may be created when localities use their local tax dollars to support certain services.
3. The State should adequately fund a minimum level of services to assure consistent services throughout the region.
4. DMHMRSAS needs to work with the Department of Medical Assistance Services so that Medicaid supports services that MH deems essential for recovery. Medicaid must be revamped to become more flexible.
5. The services system must be responsive to the need of persons who have Medicaid as a payer as well as those who do not.
6. DMHMRSAS should seek simplification in administrative processes and reporting.
7. The system needs a more coordinated approach at the State level, one that supports a single vision for a system of care.
8. DMHMRSAS leadership is essential in defining short-and long-term role of State facilities.
9. Facilities should be encouraged to put in practice reinvestment and restructuring concepts that complement and support those in the local system.

REGION 5 STRATEGIC PLAN – EASTERN VIRGINIA

STRATEGIC ISSUE # 1: COMMUNITY-BASED SERVICES

Goal 1: Implement a children's services demonstration project with a local, CSB-managed residential component, completely integrated with CBS services, to model a system of care approach.

Goal 2: Advocate re-focusing Medicaid away from a medical model toward support of a recovery model

Goal 3: Partner with advocates to build a critical mass of support for mental illness prevention and mental health promotion

Goal 4: Build programming around mental health and substance abusing consumers who enter the system through criminal justice

- a. Increase education about mental illness and substance abuse for judges, attorneys and law enforcement officials
- b. Design interventions to precede incarceration
- c. Advocate/support additional drug and mental health courts

Goal 5: Fund and implement a pilot "Recovery House" model as a crisis intervention and stabilization alternative to hospitalization (Components would include step down, diversion from acute care, peer support, support groups, community liaison)

Goal 6: Explore supporting and expanding employment and vocational opportunities for consumers (without adversely

impacting benefits)

Goal 7: Establish a Center of Excellence at SEVTC, with an outreach component similar to a PACT for MR consumers

STRATEGIC ISSUE # 2: COLLABORATION

Goal 1: Establish collaborative relationships with non-traditional partners

- a. Seek out collaboration with the military, business community, faith community, educational institutions, private medical sector and foundations
- b. Foster collaborations to develop access to leadership talent

Goal 2: Build a focused regional advocacy initiative to involve and educate consumers, families, local and state elected officials, and judges around mental health, substance abuse and mental retardation issues

- a. Identify sub-regional issues
- b. Create and disseminate a consistent message
- c. Provide leadership and guidance to empower advocates

Goal 3: Explore cross-jurisdictional linkages

- a. Identify geographic centers for shared services (e.g., – Churchland, Suffolk/Franklin)
- b. Research transportation options to improve effectiveness and efficiency of community-based service delivery

Goal 4: Adopt and promote a “no wrong door” philosophy within CSB disability areas and among other local agencies in support of a “whole person” approach to services

- a. Streamline access to intake
- b. Expand cross training
- c. Articulate a commitment to customer service and train to support it
- d. Explore opportunities for more proactive transitions (from adolescent to adult services, from one jurisdiction to another)

Goal 5: Maintain and support HPR-5 partnership

STRATEGIC ISSUE # 3: FUNDING

Goal 1: Reduce dependence on Medicaid

- a. Assess viability of future Medicaid funding
- b. Explore opportunities for public-private contracts with fee-splitting arrangements and management services
- c. Build in-house capacity for revenue generation

Goal 2: Aggressively advocate for increased funding

- a. Pursue strategic partnerships to support funding requests
- b. Build advocacy network to strengthen voice

Goal 3: Consolidate administrative processes in smaller jurisdictions (Ex. – purchasing)

Goal 4: Explore private sector alternatives to state pharmacy services

Goal 5: Ensure support for current level of funding by using evidence-based practices, delivering on effective outcome measures and effectively utilizing funds for expanded services

STRATEGIC ISSUE # 4: QUALITY OF CARE

Goal 1: Conduct a cost-benefit analysis of current utilization of high-cost children's services, including assessment of Medicaid, CSA and local funding supports

Goal 2: Adopt a commitment toward requiring evidence-based practice in all programming

Goal 3: Support a cultural shift from quality assurance (retrospective) to quality improvement (prospective)

- a. Explore and support relationships between chart reviews and the human factor
 - o Consumer satisfaction surveys
 - o Consumer involvement on quality improvement councils

Goal 4: Establish system-wide accountability to reduce paperwork without sacrificing quality

- a. Address inconsistent licensure interpretation and documentation requirements (State-level action)
- b. Identify and address inconsistencies between licensing and Medicaid regulations (State-level action)
- c. Create core forms for state-wide use
- d. Develop uniform data collection and data sharing protocols and systems

STRATEGIC ISSUE # 5: HUMAN RESOURCES

Goal 1: Broaden regional training efforts

- a. Develop region-wide opportunities to accrue contact hours and other continuing education
- b. Expand use of technology for training and competency development
- c. Partner with local educational institutions to develop “real world” curricula, improve meaningful internships and establish “MSW cohorts” within agencies

Goal 2: Share recruitment innovations

Goal 3: Establish a regional Human Services Leadership Academy to develop skills in leadership, management and supervision throughout CSB staff

STRATEGIC ISSUE # 6: RURAL ISSUES

Goal 1: Advocate for reimbursement differential for rural areas to compensate for unique services delivery issues, such as travel costs

Goal 2: Explore technology to improve access to training for staff in rural agencies

Goal 3: Explore collaboration in benefits procurement and management

HPR-5 PARTNERSHIP RECOMMENDATIONS FOR STATE-LEVEL ACTIONS

Administrative Requirements to Move From a Patriarchal Medical Model to a Recovery Model.

1. Review all administrative requirements that are in State Board policy, the performance contract, CCS, licensure regulations and human rights regulations with the goals of:
 - Negotiating annually with the local Boards to reduce paperwork requirements by an established percentage;
 - Aligning regulations in support of the recovery model; and
 - Eliminating the layering of regulations and coordinating the alignment of regulations.
2. Review the performance contract for relevance and effectiveness, and to focus on the requirements of the primary payor.
3. Adopt same standards of accountability for public and private provider.
4. Exercise leadership to resolve conflicts between regulatory interpretations.
5. Accept accreditation and HIPAA standards in lieu of, rather than in addition to, departmental standards wherever applicable.

Department’s Structure and Role as Partner

1. Reorganize the Department around function versus disability area.
2. Eliminate separate Assistant Commissioners for facilities and communities; create one Assistant Commissioner to serve both.
3. Demonstrate commitment to the state-local partnership through re-organization, policy development and proactive, inclusive problem solving.

Resource Development to Assure Some Core Level of Services Regardless of Service Setting

1. Create a dedicated funding stream for CSBs.
2. Adopt and support the concept of funded plans of care in which funding is attached to the consumer as he or she moves through the system.
3. Ensure current levels of funding; advocate against decreases in Medicaid funding.
4. Aggressively pursue means by which to increase the total amount of available funding:
 - Advocate for increased Medicaid reimbursement;
 - Advocate for increased percentage of individuals eligible for Medicaid based on diagnosis;
 - Sell downsized state facilities, build smaller complexes and re-direct savings to local CSBs
5. Assure that CSBs will be the sole provider of case management services
6. Create and implement a plan to articulate how the Department will respond to future funding changes, such as:
 - Medicaid changes at the federal level
 - State funding reductions
 - Inadequate and stagnant reimbursement levels
 - Reductions in covered services
 - Changes in other revenue sources or resources

Leadership

1. Assist localities build capacity in all disability areas
 - Address residential capacity issues
 - Funding
 - Zoning
 - Help localities meet needs for the recovery model
 - Employment services
 - Transportation
 - Medical care
 - Medication for indigent consumers
 - Socialization
 - Develop consistent outcome measures
 - Set standards for caseload size
2. Identify and address state-wide issues
 - Provide centralized bed management
 - Negotiate with DMAS to determine responsibility for indigent beds
 - Identify and articulate the State's position on TDOs and the admission criteria for TDO facilities
3. Generate a workforce development plan at the State level
 - Initiate efforts with community colleges, colleges and universities to train staff
 - Develop initiatives with institutions of higher learning to attract graduates to the field
 - Establish scholarship opportunities
 - Eliminate disincentives, such as lack of reimbursement for psychiatric services
 - Review QMHP requirements

Communication to Ensure Effectiveness, Efficiency and Mutual Trust

1. Establish regular channels of communication with leaders in the community.
2. Establish and adhere to policies and procedures to ensure timely response to local requests for information and policy interpretation.

3. Ensure consistent communication among internal divisions in the Department.
4. Respond to and act upon recommendations from CSB Executive Directors.

REGION 6 STRATEGIC PLAN – SOUTHERN VIRGINIA

1. Fund additional Discharge Assistance Project (DAP) plans (Danville 14, Piedmont 12, and Southside 7)
2. Expand existing Purchase Inpatient Services fund to reduce CSB admissions to SVMHI by half.
 - a. Change focus of SVMHI to serve longer-term patients
 - b. Implement the Consortium's Utilization Management Plan.
3. Implement two PACTs to provide PACT services in each of the three participating Consortium CSBs.
4. Expand the existing Regional Consortium as a more formal entity.
 - a. Work with the Virginia Tech Institute for Innovative Governance, School of Public and International Affairs to develop a "vision" of long-term goals for the region.
 - b. Consider the possibility of establishing a non-profit, legal entity.
 - c. Refine the planning process that will involve a more comprehensive representation of stakeholder/providers of services and consumers.

Regional Partnership Recommendations for State-Level Action:

1. Provide funding for DAP, POS and PACT services.

HPR 7 STRATEGIC PLAN – CATAWBA AREA

1. Provide a comprehensive system of appropriate crisis diversion and treatment, both inpatient and outpatient, for adults with mental illness and a co-occurring disorder such as mental retardation or substance abuse, if present.
 - a. Expand crisis stabilization capacity.
 - b. Develop increased response with intensive supports and case management so crisis clients can avoid hospital admissions.
 - c. Purchase of inpatient beds for post commitment patients who are awaiting transfer to Catawba Hospital.
 - d. Increase communication and cooperation between CSB Crisis Services programs, RESPOND (L-G) and CONNECT (Carilion).
2. Explore and develop alternative treatments for adults with acquired brain injury in cooperation with the Brain Injury Association of SW Virginia.
 - a. Liaison with BIASWV to determine appropriate methodologies and resources for people with Acquired Brain Injury.
 - b. Receive education and guidance from BIASWV and health care systems to determine most appropriate care for patients with brain injury requiring structure and control.
3. Ensure access to critical information following appropriate AHIMA/HIPAA regulations within 24 hours of request.
4. Develop an appropriately manned task force to address treatment protocols and critical pathways for common treatment modalities across the region.
 - a. Engage University of Virginia Medical Education/Residency.
 - b. Identify most appropriate individuals from area institutions and agencies to define common areas of treatment concerns.
 - c. Establish clear objectives and timelines for completion of the task with disincentives for noncompliance.

Regional Partnership Recommendations for State-Level Action:

1. Finalize the Pharmacy plan by completion of the Memoranda of Understanding between DMHMRSAS and BRBH.

Catawba Region Child/Adolescent Work Group Report Recommendations

1. Develop additional capacity for traditional front door, outpatient services inclusive of stand alone assessment and intake and as well additional outpatient therapy availability.
2. Further examine the ability to increase psychiatric capacity within the current system of services.
3. Provide support and leadership, in partnership with other core agencies to develop interagency guidelines for transition of youth into adult services.
4. Partner with other child-serving agencies to develop a "road map" for child and family services across the broader service system of core agencies and private providers.
5. Continue to provide support for the successful attainment of the CSA Regional Steering Committee's primary goal: to develop a short-term evaluation and residential facility within the region.

CHILD AND ADOLESCENT SPECIAL POPULATIONS WORK GROUP RECOMMENDATIONS

DMHMRSAS should adopt the system of care model developed by the Georgetown University's Technical Assistance Center for Children's Mental Health and adopted by SAMHSA.

DMHMRSAS should lead the statewide promulgation of this system of care model with other state agencies, families, CSBs, and other public and private providers.

Major Funding Priorities

1. Fund four system of care demonstration projects (\$2.5 million).
2. Fund Parent/Youth Involvement Network (\$500,000 for the first year – \$1 million for second year).
3. Fund Behavioral health services provided by CSBs in detention centers during and after detention stay (\$3.5 million).
4. Maximize all resources in Virginia to build the capacity for behavioral health services that includes a comprehensive continuum of prevention, early intervention, and intensive therapeutic services.
 - a. Increase Medicaid rates for day treatment services to \$150 per day.
 - b. Add substance abuse services to the DMAS State plan and provide funding for treatment services for youth and their families with primary or secondary substance abuse diagnoses (\$5 million).
 - c. Conduct a rate study to expand community-based services in the state plan to include:
 - i. Intensive Case Management Level System in CSBs
 - ii. Parenting Education
 - iii. Respite services
 - iv. Behavioral Aides.
 - d. Fund training priorities, which follow:
 - i. Systems of Care (\$500,000 for 5 regional and 1 state training);
 - ii. Fund slots for university training of child psychiatry fellows and child psychology interns with payback provisions (\$60,000 per fellow, \$26,000 per intern).
 - e. Fund Multisystemic Therapy (MST) and Functional Family Therapy (FFT) capacity building (\$2.5 million to include training and statewide licensure, and to oversee and fund local MST/FFT services).

Other System of Care Recommendations

1. Through the DMHMRSAS, recommend to the State Executive Council and the General Assembly possible Code, regulatory changes, and budget initiatives to support the revision and expansion of state and local systems of care.
2. Include prevention and early intervention services for children and their families with or at risk of mental health, mental retardation, and substance abuse problems in the system of care.
3. Work with state agencies to continuously blend and braid funding sources to meet the needs of children and adolescents with MH/MR/SA problems and their families.
4. Support and expand the DMHMRSAS Office of Child and Family Services to assure that children's behavioral health services are prioritized and include all service entities related to children and their families.

Additional Recommendations Related to Increased Funding

1. Conduct statewide trainings on evidence-based, best practices, and promising treatments for children with behavioral health problems – statewide workshops, seminars, and cross-community trainings
2. Fund cross-state and agency National Systems of Care model training (\$200,000 managed by DMHMRSAS with VACSB)

Recommendations Not Related to Funding

1. Encourage partnerships and collaborations among parents, all providers, and other stakeholders of children and their families with behavioral health problems
2. Support the continuation of the Child and Adolescent Special Population Workgroup activities by merging the membership with the group established by Budget Item 330-F of the 2004 Appropriations Act
3. Support systems of care model including: 1) a coordinated, integrated, and individualized treatment plan; 2) families and surrogate families are full participants in all aspects of the planning and delivery of services; and 3) support a unitary (i.e., cross-agency) care management/coordination approach even though multiple systems are involved, just as care planning structures need to support the development of one care plan.
4. Promote integration of services across MHMRSA disabilities by establishing policies that require services providers to conduct a single comprehensive intake addressing the areas of MHMRSA and developing a unified services plan and record
5. Continue the dissemination of the Commission on Youth's "Collection" of evidence-based practices
6. Seek grant funding to enhance child and adolescent behavioral health services by establishing matching fund capacity through private foundations/corporations
7. Strengthen university/community partnerships to enhance child and adolescent behavioral health services
8. Encourage DMAS to "suspend" rather than "terminate" Medicaid benefits while children and adolescents are in a public institution including state hospitals, juvenile detention centers, juvenile correctional facilities, and jails.

Geriatric Special Populations Work Group Recommendations

General Recommendations for Improving the System of Geriatric Services

1. Develop a Master Plan for Geriatric Services, outlining a standard continuum of specialized services to meet the complex needs of geriatric patients.
 - a. Specify the types, levels, and scope of services to be provided, expected programs and schedules, staffing, and funding requirements.
2. Establish additional community-based services to meet current unmet services needs.
 - a. Add geriatric specialists at Community Services Boards.
 - b. Create more community-based residential treatment services that could be used as an alternative to more restrictive institutional placements.
 - c. Create an office or division within DMHMRSAS to provide more focus and support for this effort.
3. Maintain state hospital geriatric beds.
 - a. Continue to test alternatives that may be less costly or more community-based than the state hospital.
 - b. Strengthen coordination and planning between state hospital specialists and community providers, including the CSBs, to maximize community placements and enable community providers to access hospital staff expertise.
4. Quantify the increased geriatric services that will be needed at each level in the continuum of services, in response to a rapidly growing geriatric population that will approximately double over the next 25 years.
 - a. Continually expand funding, staffing, space, and services structures to handle the growing numbers of geriatric consumers.
5. Conduct extensive reviews of those approaches (model programs) that have been successful in providing

effective treatment and quality-of-life to geriatric consumers and their families, so we can capitalize on those approaches in Virginia.

- a. Learn from how other states have structured their geriatric services, as well as from effective approaches used Virginia.
- b. Recognize staff operating effective programs, and information disseminated to promote use of the programs by others.
6. Develop standard data sets and reports that can be used in planning needed services, evaluating services outcomes, and making improvements.
 - a. Collect population data to show current and projected geriatric population by various localities.
 - b. Collect data on availability of services providers by type and location.
 - c. Collect data that reflects the comparative costs and outcomes of various services.
7. Maximize the use of Medicaid and Medicare, and grants in support of needed services.
 - a. Look for increased flexibility in making the best use of available funding within federal guidelines.
 - b. Test new programs using demonstration grants when feasible.
 - c. Encourage DMHMRSAS and DMAS to work collaboratively to identify strategies to remove barriers to funding needed community-based geropsychiatric services.
8. Provide ongoing coordination between the agencies delivering services to geriatric patients.
 - a. Conduct joint planning, review of service delivery, collaborative problem solving, and continuing reviews of outcomes of services.
9. Inform and educate consumers and families about available services and entitlements, and how to access them.
 - a. Through multi-agency efforts, organize needed information in useable forms and get it into the hands of consumers.
10. Increase supports to family caregivers, to enable them to provide care to geriatric consumers as long as possible, reducing demands on public-provided services.
 - a. Provide assistance with the costs and daily demands of caregiving to family caregivers so geriatric consumers at home longer
11. Strengthen training and continuing education of caregivers.
 - a. Identify where the gaps are in reaching caregivers with necessary training.
 - b. Make better use of existing training resources to meet the needs.
12. Increase supports to long term care facilities.
 - a. Make geropsychiatrists and related mental health professionals available to Nursing Homes and Assisted Living Facilities to help them to manage residents with severe mental illness and dementia.
 - b. Provide hands-on training and live supervision on mental health issues
 - c. Update old and new staff on how to handle a range of demanding problems and how to adapt their approaches to individual patients.
13. Develop partnerships with primary physicians and work through various agencies to extend continuing education to them, for the purpose of improving detection of mental illness and referral to specialists.
 - a. Plan effective continuing education has to be done in partnership with physicians and other professional providers to assure programs match their educational levels and scheduling is realistic given the demands of their practices.
 - b. Involve the relevant professional agencies and boards.
14. Develop a specialized focus on geriatric consumers having both mental illness and dementia.
 - a. Designate this population as needing the same specialty status and funding for training as other dually diagnosed populations.

- b. Revise Virginia Medicaid criteria to support proper care for elderly persons with severe behavioral problems and to reflect modern understandings of the origins of mental disorders as well as evidence-based treatment practices.

Specific Initiatives for 2004-2005

1. A Beacons Program -- Identify, recognize, and promote examples of model programs (or program components) operating in Virginia.
2. Educational Program for Physicians -- Prepare and educational program in collaboration with appropriate agencies and professional organizations, to reach primary care physicians and geriatric specialists who treat geriatric consumers.
3. Compilation of Training Resources -- Compile training resources by region that can be accessed by providers, consumers, and families.
4. Compilation of Geriatric Services -- Compile a directory of geriatric services that includes descriptive information about available services by region, information on entitlements, and how to access services.
5. Obtain Data for Planning -- Review existing databases that could be useful in planning geriatric services and extract preliminary data for use by the Geriatric Team.

MENTAL RETARDATION SPECIAL POPULATIONS WORK GROUP RECOMMENDATIONS

MR Special Population Workgroup Mission Statement

Rebalance Virginia's service system to become more individually focused where people receive services in the community, based on their individualized needs regardless of funding source. This will be accomplished by building capacity for those persons with all levels of developmental disabilities inclusive of co-occurring conditions, which are funded in a manner that is consistent with the values of self-determination.

Short-Term Recommendations

1. Provide training to increase the expertise of community professionals and paraprofessionals to ensure that service providers have the knowledge, skills, and abilities to address current client needs, evolving complexity of client care, and the decreasing skills of the available workforce for entry-level client care positions.

Policy –

- a. Extend licensure system to identify providers offering specialty programs and licenses for specialty programs (a tiered license program with specialty certification).
- b. Develop a tiered licensing program with specialty certification.
- c. Link licensure for specialty programs with training requirements to ensure needed staff knowledge, skills and abilities.
- d. Prioritize development/expansion of community and facility services to those with dual diagnosis.

Administrative –

- a. Create Memos of Agreement, signed by DMHMRSAS Directors' of MR, MH, and SA, to establish leadership for an overarching philosophy of a client needs-based system of treatment, rather than the current disability-based system.
- b. Enhance CSB performance contracts by requiring cross training in assessment and treatment of persons with dual diagnosis.
- c. Identify current best practice training programs for community MR services. Establish a standardized training curriculum for CSB case managers, as well as for private provider residential and vocational staff. Develop other training curriculum as needed.
- d. Support provider participation in training curriculum to assure minimum standards of training for all staff. (e.g., by supporting the direct care professional training through The College of Direct Support from the University of Minnesota program).

Appropriations –

- a. Support funding for development of a standardized training curriculum.
- b. Support funding for training materials and costs of trainers.
- c. Support supplement funding for community providers so they can obtain reimbursement for direct care staff's pay during required training.
- d. Support funding for development of MR/MI PACT Teams.
- e. Provide incentives for clinical providers to attend training, such as CEU's and tax credits.

Services –

- a. Expand service options for children/adolescents with MR with strong emphasis on in-home family supports.
 - b. Provide cross training of CSB MH, MR and SA staff at all levels. Adopt mandatory performance expectations for direct care/clinical staff in the assessment and treatment of persons with dual diagnosis.
 - c. Identify and/or develop regional experts to provide consultation and training to community clinical providers.
 - d. Develop regional MR/MI PACT Teams.
2. Develop policies that do not have a negative financial impact on community private providers when clients need temporary out-of-home placements (e.g., hospitalization) or spend time with family to sustain relationships. Recognize that funding the individual includes, and requires, that the person have stable housing.

Policy –

- a. DMHMRSAS to fully support the assertion that residential private providers are providing a essential resource that is vital to community integration of clients, and therefore, capacity to hold the residential placement during temporary out-of-home placements is critical to successful community integration.

Administrative –

- a. Direct DMHMRSAS to work with DMAS and other agencies to resolve the discrepancy between the individual's need for stable, continuing housing and current Waiver funding constraints to maintain placements when out-of-home services are needed.

Appropriations –

- a. Conduct analysis of costs regarding current duration and reasons for client absences from community placements.
 - b. Create an equitable mechanism to allow reimbursement of both ICF/MR and MR Waiver programs for consumer absences due to hospitalization and other temporary circumstances in order to maintain a person's home.
3. DMHMRSAS request increased funding for community services each year, specifically related to maintenance of current services (e.g., utilization, inflation, and COLA) and expansion of services.

Policy –

- a. Develop DMHMRSAS requests for funding to community services so that adequate levels and capacity of services are maintained and/or developed to meet the needs of persons with MR. In collaboration with appropriate state agencies and regional reinvestment committees, DMHMRSAS budget development should address:
 - Analysis of regional environmental factors (i.e., economy, workforce availability & competition, unemployment and population trends).
 - Identification and analysis of the per capita rate and number of persons who are uninsured in each region.

Administrative –

- a. In collaboration with appropriate state agencies and regional reinvestment committees, DMHMRSAS should conduct a formal needs assessment of regional services to persons with MR.

Appropriations –

- a. Expand the types of Medicaid Waivers for MR community services. Provide increased funding at levels that will ensure maintenance and stability of current community services as well as necessary expansion.
4. Create a statewide database that matches needed supports of persons with developmental disabilities with qualified providers. This database will be also used for planning future service needs and funding requests.

Policy –

- a. Through the DMHMRSAS Office of Mental Retardation, spearhead a system-wide effort to collect and maintain a database that facilitates the match between consumers, service needs, and providers of residential and vocational options.

Administrative –

- a. The Database Subcommittee of the MR Special Populations Work Group will develop recommended data elements for the profile needs of providers, consumers and services.
- b. DMHMRSAS will develop a statewide database system for this purpose using existing databases where appropriate.

Appropriations –

- a. Identify and provide necessary funding for DMHMRSAS staff to develop, implement, and maintain the database.
- b. Identify and provide necessary funding to support on-going training and use of the database by the Office of Licensure, Office of Mental Retardation, CSB case management staff, and private providers.
5. Improve overall funding to promote and reward best practice support strategies for all staff in order to increase stability of direct support professionals through:
 - Training, development, and credentialing
 - Tax credits to employers and providers
 - Staff salaries and benefits that reflect regional economic and other environmental factors (e.g., job competition, workforce availability, cultural diversity, etc.)

Policy –

- a. Establish legislation that ensures the continuation of adequate funding for the community-based system through adoption of public policy that includes an annual cost of living increase for all services.

Administrative –

- a. Increase collaboration between DMHMRSAS and other State agencies to obtain additional funding from Federal sources (i.e. SAMHSA for dual diagnosis projects).
- b. Develop DMHMRSAS funding requests for community services so that adequate levels and capacity of services are maintained and/or developed to meet the needs of persons with MR.
- c. In collaboration with appropriate state agencies and regional reinvestment committees, address regional factors (i.e., economy, workforce availability & competition, unemployment, cultural diversity, and population trends) in DMHMRSAS budget development.

Appropriation –

- a. DMHMRSAS will encourage funding of such initiatives with the support of advocacy organizations.
- b. DMHMRSAS should submit a proposal to the General Assembly to provide supplemental funding to community providers for training of direct care staff due to lack of reimbursement for staff pay when a client is not yet residing in the home (i.e., as a part of start-up costs).

Services –

- a. Support provider participation to assure minimum standards of training for staff (e.g. by supporting the direct care professional training through the College of Direct Care University of Minnesota program).
- b. Expand the types of Medicaid Waivers for MR community services.

SUBSTANCE ABUSE SPECIAL POPULATIONS WORK GROUP RECOMMENDATIONS

Policy Actions

Funding

1. Target Reinvestment funds to support services for the populations with co-occurring MH/SA, both children and adults.
2. Make the expansion of Medicaid coverage for the treatment of substance use disorders a Departmental priority:
 - The Commissioner and other Departmental leadership should influence the Secretary of HHR to require DMAS to include DMHMRSAS in policy development and implementation regarding SA, including the Family Access to Medical Insurance Security (FAMIS) Plan, EPSDT, FAMIS Plus, and general Medicaid funds;
 - The Office of Substance Abuse Services should develop and disseminate a policy paper supporting the use of Medicaid for SUDs; and
 - Provider organizations should demonstrate strong support for key legislators to initiate budget bills for Medicaid expansion.

Improving the Stature of the Office

1. The Department should establish SA specific representation on the System Leadership Council by including the chair of the SA Council of the VACSB, the chair of the Prevention Task Force of the VACSB, the Chair of the SA Services Council and the President of the Virginia Association of Drug and Alcohol Programs (VADAP).
2. OSAS should work to strengthen and develop the burgeoning research partnership between VCU (including MCV), OSAS and the CSBs.
3. The Department should include private sector leadership (VADAP and VADAAC) in systems planning and service delivery execution.
4. The Department, working through the Secretaries of HHR and Public Safety and the Substance Abuse Services Council, should promote closer involvement with the criminal justice system in the development of quality standards for assessment and service delivery.

Data

1. The Department should assure compliance with the requirements of § 37.1-207.
2. The Department should support the development and use of appropriate outcome measures to demonstrate cost offsets of providing treatment and prevention services.

Advocacy

1. The Department should continue to support the development of organized advocacy efforts.
2. The Department should continue to emphasize consumer involvement and empowerment in all aspects of treatment.
3. The Department should encourage and improve advocacy activities that provide educational information about specific issues related to substance use disorders.

Program Actions

Funding

1. The Department should host a "summit" to explore and develop ideas about the use of Medicaid to support treatment for substance use disorders.
2. OSAS should invite DMAS staff to training and other events that would enhance understanding of substance use disorders.
3. The Department should develop a mechanism that supports tracking funds with specific consumers affected by facility diversion.
4. OSAS should continue to provide technical assistance to other state agencies and to community-based programs seeking competitive grant funds.
5. OSAS should continue to compete for grant funds that would support its mission and goals.

Office Stature

1. OSAS, in conjunction with an interagency work group that includes CSBs, private providers and consumers, should develop "best-practice"-based standards for treatment programs supported with public funds that will form the foundation for future regulatory action.

Data

1. OSAS should work closely with the Substance Abuse Services Council in developing its report on and implementing responsibilities related to implementing § 37.1-207.
2. OSAS should develop a "how to" manual to support local program ability to evaluate outcomes.
3. OSAS should develop a *logic model* to support resource allocation and program design.

Advocacy

1. OSAS should continue to provide technical support to SAARA regarding organizational growth and leadership development.
2. OSAS should publish research-based reports that substantiate the cost-effectiveness of substance abuse services.

FORENSICS SPECIAL POPULATIONS WORK GROUP RECOMMENDATIONS

1. Establish the following goals for the provision of community-based mental health services to individuals in the criminal justice system with serious mental illness:
 - a. Minimize the number of non-violent individuals with mental illness or serious substance abuse disorders in the criminal justice system
 - b. Enhance the delivery of mental health services to incarcerated individuals, both to reduce demand for hospitalization and to prevent re-hospitalization of individuals returned to incarceration following inpatient treatment & evaluation
 - c. Provide access to hospital care, when appropriate, with minimum delays, so that the resulting length of hospitalization may be reduced, and the management of mentally ill individuals in the jail may be enhanced.
 - d. Require appropriate cross-training for key players in both the mental health and criminal justice services communities.
 - e. Provide adequate resources to localities, so that required systems changes can be implemented.
2. Continue to respond to the mandates of SJR 81, of the 2004 General Assembly, and related budget language requiring the DMHMRSAS to develop a web-based program for the sharing of innovative practices for the treatment of individuals with mental illness and substance abuse treatment needs, and to continue the activities of this work group. (Although the DMHMRSAS has recently implemented a web-based program of this type, additional follow-through work is needed in this area.)
3. Devote additional study and analysis to the issue of substance abuse among the offender population. Substance abuse constitutes a key or overriding problem faced by all of the populations targeted by the work group agenda.
4. Support implementation of the plan of recommended actions that has been submitted by the Juvenile Justice Subcommittee of the Child and Adolescent Special Populations Work Group.
5. Through budgetary language and funding initiatives with the Virginia General Assembly, complete the following actions:
 - a. Develop a model Community Policing curriculum for Crisis Intervention Training for law enforcement officers in all jurisdictions of the Commonwealth.
 - b. Support in language and with resources the improved access of the courts in Virginia to the services of expert mental health evaluators.
 - c. Direct the implementation of, and provide sufficient resources to develop a statewide cross-training program, developed through the DCJS, in all relevant areas of mental health and substance abuse

- assessment and treatment, geared toward law enforcement, jail personnel, court personnel, and mental health personnel having involvement with service delivery in the criminal justice system.
- d. Direct the development of, and provide resources for implementing a joint VACSB/DMHMRSAS/law enforcement information sharing system.
 - e. Endorse and direct the provision of renewable resources for the continuation of those model Virginia programs that are currently funded by temporary federal grants, or do not have a specified funding stream, such as the Montgomery County Crisis Intervention (CIT) program, the Chesterfield Day Reporting Center, and the Norfolk Mental Health Court.
 - f. Direct the DMHMRSAS and the Virginia CSBs to implement the community-based Restoration to Competency To Stand Trial program that has recently been developed on a statewide basis. Provide sufficient funding and other needed resources for each CSB to accomplish this goal.
 - g. Provide resources and budget language to develop pilot jail MH and SA services programs, based upon evidence-based approaches, for at least 3 Virginia jails.
 - h. Using a pilot program approach, provide resources and directives necessary for the development of additional mental health courts in the Commonwealth.
 - i. Provide resources necessary to develop the means for the Department of Corrections, the DCJS, the Virginia Board of Compensation, and local and regional jails, in conjunction with the DMHMRSAS, to accurately depict the current population of inmates having serious medical illnesses, mental illness and substance abuse disorders in local, regional and state correctional facilities, and under the supervision of DOC Community Corrections and local offices of probation and parole.
 - j. Allocate sufficient resources and provide directives to develop a statewide, multi-agency approach toward planning and providing a model pharmacy and drug formulary program that will ensure the use of "best practices" in selecting the range and types of medication to be used by medical providers in the jails and prisons of the Commonwealth.
 - k. Provide for the allocation of DMHMRSAS resources for the maintenance and upgrading of the Forensic Information Management System (FIMS).
 - l. Provide language and resources to ensure that there is an adequately trained group of forensic mental health evaluators available throughout the state to conduct court-ordered evaluations on an outpatient basis.
 - m. Direct and denote resources for the implementation by the DMHMRSAS of a comprehensive program for training mental health and criminal justice professionals and others in evidence-based, "best practices" approaches to the provision of community-based and facility-based mental health and substance abuse treatment modalities for individuals with criminal justice system involvement.
6. Change Virginia Medicaid regulations in the following ways: Provide for "suspension", rather than "termination" of Medicaid benefits to recipients who are incarcerated in local and regional jails. Alter Virginia Medicaid regulations to provide for reimbursement to providers of Substance Abuse treatment services to Medicaid recipients.
 7. Endorse the concept of designation of community psychiatric facilities as proper treatment sites for nonviolent criminal defendants in need of acute care.
 8. Promote the successful adoption of the recommended changes requested of the Office of the Executive Secretary of the Supreme Court of Virginia (OESSCV) by DMHMRSAS Commissioner Reinhard, regarding forensic evaluations services, in his letter of July 6, 2004 to Secretary Baldwin.
 9. Continue to develop procedures for DMHMRSAS psychiatric hospitals to complete outpatient evaluations for the courts, and continue to work with the criminal courts to divert evaluations to community providers, wherever appropriate.
 10. Encourage the review and appropriate modification of DMHMRSAS inpatient programs for individuals found "Not Guilty by Reason of Insanity (NGRI)" or "Unrestorably Incompetent to Stand Trial (URIST)", as well as "mandatory parolees".
 11. Consult with the Virginia Board of Corrections regarding the need to expand upon the current mental health

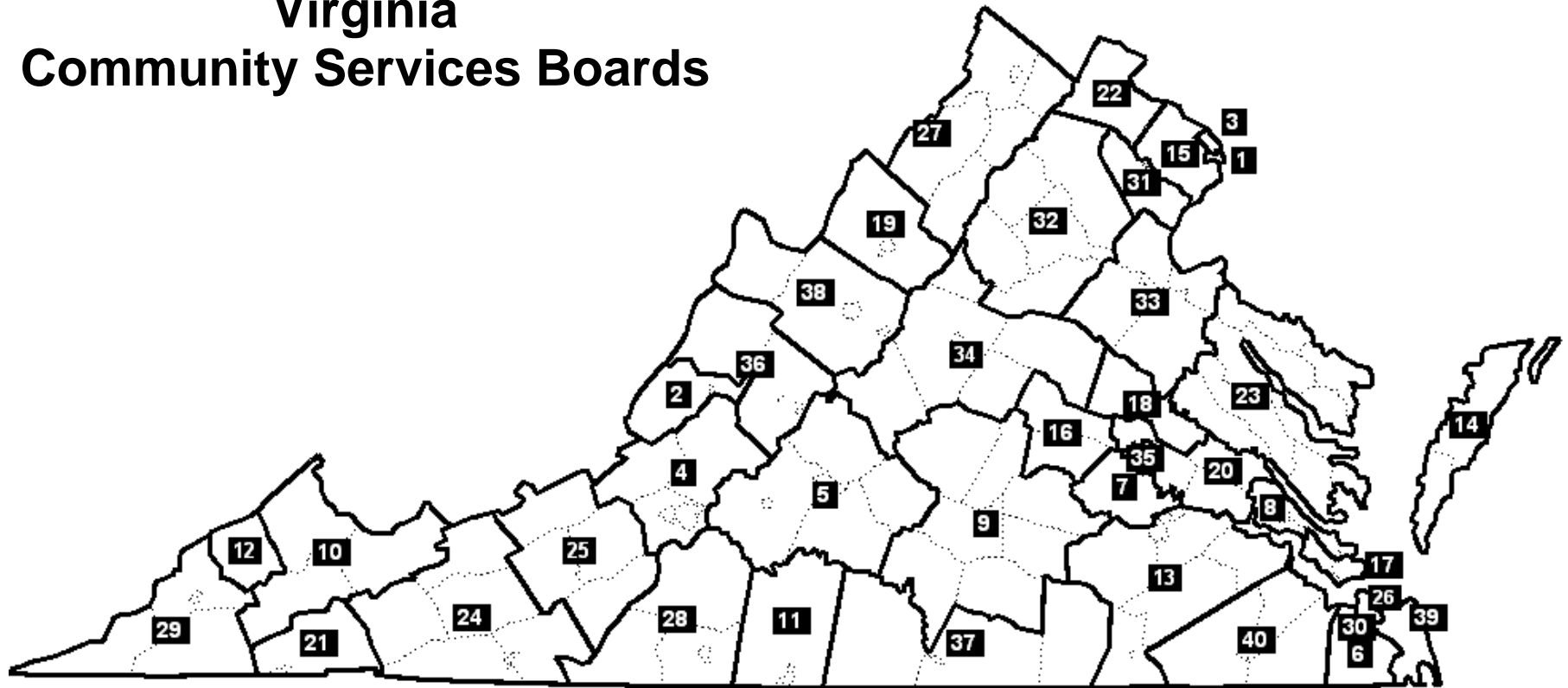
standards set by that body for local and regional jails, in *Virginia Administrative Code* § 6VAC15-40-1010.

12. Integrate the activities of the Governor's NGA Policy Team for Prisoner Reentry with this work group process, as feasible.
13. Continue to identify and recommend all necessary changes in these areas that shall be required to implement each programmatic goal of the work group: Funding/resource allocation needs; local/state policy changes; memoranda of agreement for designated activities; changes in the *Code of Virginia*, or *Virginia Administrative Code*; licensure/certification procedures needed; human rights procedural guarantees.

Appendix B

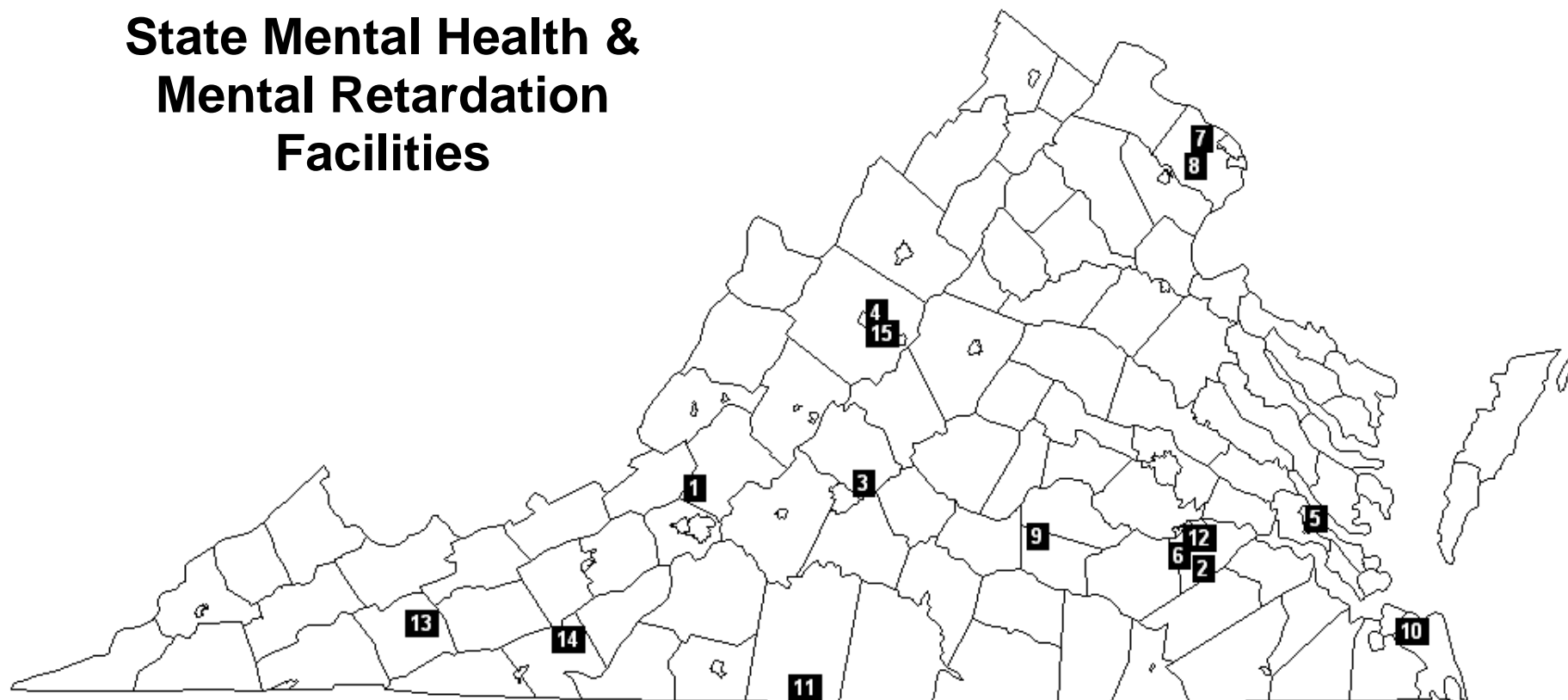
Maps of Community Services Board Service Areas and State Mental Health and Mental Retardation Facility Locations

Virginia Community Services Boards



1	Alexandria	11	Danville-Pittsylvania	21	Highlands	31	Prince William
2	Alleghany Highlands	12	Dickenson	22	Loudoun	32	Rappahannock-Rapidan
3	Arlington	13	District 19	23	Mid Peninsula-Northern Neck	33	Rappahannock Area
4	Blue Ridge	14	Eastern Shore	24	Mount Rogers	34	Region Ten
5	Central Virginia	15	Fairfax-Falls Church	25	New River Valley	35	Richmond
6	Chesapeake	16	Goochland-Powhatan	26	Norfolk	36	Rockbridge Area
7	Chesterfield	17	Hampton-Newport News	27	Northwestern	37	Southside
8	Colonial	18	Hanover	28	Piedmont	38	Valley
9	Crossroads	19	Harrisonburg-Rockingham	29	Planning District 1	39	Virginia Beach
10	Cumberland Mountain	20	Henrico Area	30	Portsmouth	40	Western Tidewater

State Mental Health & Mental Retardation Facilities



<u>Facility</u>	<u>Location</u>	<u>Facility</u>	<u>Location</u>
1 Catawba Hospital	Catawba	9 Piedmont Geriatric Hospital	Burkeville
2 Central State Hospital	Petersburg	10 Southeastern VA Training Center	Chesapeake
3 Central VA Training Center	Madison Heights	11 Southern VA Mental Health Institute	Danville
4 Commonwealth Ctr. for Children & Adolescents	Staunton	12 Southside VA Training Center	Petersburg
5 Eastern State Hospital	Williamsburg	12a Behavioral Rehabilitation Center	Petersburg
6 Hiram W. Davis Medical Center	Petersburg	13 Southwestern VA MH Institute	Marion
7 Northern VA MH Institute	Falls Church	14 Southwestern VA Training Center	Hillsville
8 Northern VA Training Center	Fairfax	15 Western State Hospital	Staunton

Appendix C

Community Services Board Services Utilization and Condensed Core Services Taxonomy 7 Definitions

Community services boards (CSBs) offer varying combinations of six core services, directly and through contracts with other organizations. Table 1 displays trends in numbers of consumers served between state FY 1988 and 2004 by program area. Tables 2 through 5 display information about static capacities and units of service provided in state FY 2004, which started on July 1, 2003 and ended on June 30, 2004. All tables show actual data, derived from 4th quarter performance reports submitted by CSBs.

Table 1: Consumers Served by CSBs*

FY	Mental Health		Mental Retardation		Substance Abuse		TOTAL	
	Undupl. ²	Dupl. ³	Undupl. ²	Dupl. ³	Undupl. ²	Dupl. ³	Undupl. ²	Dupl. ³
1988	110,082	161,033	14,354	22,828	57,363	80,138	181,799	263,999
1989	107,892	157,825	17,361	27,610	62,905	87,878	188,158	273,313
1990	NA	152,811	NA	30,198	NA	101,816	NA	284,825
1991	NA	161,536	NA	28,539	NA	103,288	NA	293,363
1992	NA	160,115	NA	27,525	NA	78,358	NA	265,998
1993	105,389	158,115	19,010	27,696	55,871	80,271	180,270	266,082
1994	107,131	168,208	19,742	28,680	59,471	87,166	186,344	284,054
1995	106,637	177,320	18,572	29,141	61,463	88,471	186,672	294,932
1996	116,344	174,126	19,169	30,006	64,309	90,750	199,822	294,882
1997	115,169	179,500	20,557	30,655	63,040	90,099	198,766	300,254
1998	119,438	185,647	20,983	32,509	68,559	96,556	208,980	314,712
1999	112,729	178,334	21,772	33,087	64,899	93,436	199,400	304,857
2000	118,210	180,783	22,036	26,086	61,361	88,358	201,607	295,227
2001	105,169	178,254	23,843	33,238	59,968	102,037	188,980	313,529
2002	107,351	176,735	24,903	33,933	59,895	91,904	192,149	302,572
2003	109,025	180,110	25,207	34,103	57,526	86,979	191,758	301,102
2004	109,175	181,396	23,925	35,038	53,854	78,008	186,954	294,442

NOTES:

- * Unduplicated counts of consumers were not collected by the Department every year. The NA notations show years in which this information was not collected.
- 2. Unduplicated (**Undupl.**) numbers of individuals are the total number of consumers receiving services in a program (mental health, mental retardation, and substance abuse services) area, regardless of how many services they received. If a person with a dual diagnosis (e.g., mental illness and substance abuse) received services in both program areas, he would be counted twice.
- 3. Duplicated (**Dupl.**) numbers of individuals are the total numbers of consumers receiving each category or subcategory of core services. Thus, if a person received outpatient, rehabilitation, and supervised residential services, he would be counted three times, since he received three services. These totals are added to calculate a total number for each program area.

With the implementation in FY 2004 of the Community Consumer Submission (software that extracts individual consumer data from CSB information systems and transmits encrypted data to the Department) a totally unduplicated count of consumers at the CSB across all program areas, rather than in each program area is available for the first time. In FY 2004, 167,096 individuals received services from the CSBs.

Table 2: FY 2004 CSB MH Static Capacities by Service

Service	Capacity	Service	Capacity
Day Treatment/Partial Hospitalization	94.23 slots	Local Inpatient	59.25 beds
Therapeutic Day Treatment - C&A	479.00 slots	TOTAL Local Inpatient	59.25beds
Rehabilitation Services	2,326.00 slots	Highly Intensive Residential	48.00 beds
Sheltered Employment Services	22.00 slots	Intensive Residential	145.97 beds
Supported Employment - Group Models	33.00 slots	Supervised Residential	778.00 beds
TOTAL Day Support Services	2,954.23 slots	TOTAL Residential Services	971.97 beds

Note: Decimal fractions of beds and slots result from calculating these capacities for contracted services where a CSB purchases a number of bed days or days of service, which must be converted to numbers of beds or day support slots.

Table 3: FY 2004 MR CSB Static Capacities by Service

Service	Capacity	Service	Capacity
Rehabilitation Services	1,847.45 slots	Highly Intensive Residential	79.00 beds
Sheltered Employment Services	953.80 slots	Intensive Residential	727.50 beds
Supported Employment - Group Models	692.70 slots	Supervised Residential	499.02 beds
TOTAL Day Support Services	3,493.95 slots	TOTAL Residential Services	1,305.02 beds

Note: Decimal fractions of beds and slots result from calculating these capacities for contracted services where a CSB purchases a number of bed days or days of service, which must be converted to numbers of beds or day support slots.

Table 4: FY 2004 SA CSB Static Capacities by Service

Service	Capacity	Service	Capacity
Local Inpatient	8.75 beds	Highly Intensive Residential	142.67 beds
Community Hospital-Based Detox	44.06 beds	Intensive Residential	609.87 beds
TOTAL Local Inpatient	52.81 beds	Jail-Based Habilitation	400.00 beds
Day Treatment/Partial Hospitalization	253.00 slots	Supervised Residential	124.28 beds
TOTAL Day Support Services	253.00 slots	TOTAL Residential Services	1,276.82 beds

Note: Decimal fractions of beds and slots result from calculating these capacities for contracted services where a CSB purchases a number of bed days or days of service, which must be converted to numbers of beds or day support slots.

Table 5: Units of CSB Services Provided in FY 2004 by Core Service

Core Service/Unit of Service	Program Area	Mental Health	Mental Retardation	Substance Abuse	TOTAL
Emergency Consumer Service Hours		347,708		44,795	392,503
Local Inpatient Services		13,052		1,631	14,683
Community Hospital-Based Detox				4,627	4,627
TOTAL Local Inpatient Service Bed Days		13,052		6,258	19,310
Outpatient Services		829,026	1,310	528,014	1,358,350
Intensive In-Home Services		254,693			254,693
Motivational Treatment Services				1,272	1,272
Case Management		964,212	525,389	147,527	1,637,173
Assertive Community Treatment		70,470			70,470
Methadone Detoxification Services				22,910	22,910
Opioid Replacement Therapy Services				91,557	91,557
Consumer Monitoring Services		1,804	5,508		7,312
TOTAL OP & CM Consumer Service Hours		2,120,205	532,207	791,325	3,443,737
Day Treatment/Partial Hospitalization		85,720		267,994	353,714
Therapeutic Day Treatment - C&A		354,669			354,669
Rehabilitation Services		2,704,037	2,193,107		4,897,144
TOTAL Day Support Hours		3,144,426	2,193,107	267,994	5,605,527
Sheltered Employment Services		4,766	183,207		187,973
Supported Employment - Group Models		6,000	132,489		138,489
TOTAL Day Support Days of Service		10,766	315,696		326,462
Supported/Transitional Employment		23,619	77,906	40	101,565
Alternative Day Support Arrangements		8,150	52,038	3,094	63,282
TOTAL Day Support Consumer Service Hours		31,769	129,944	3,134	164,847
Highly Intensive Residential Services		19,144	25,604	38,744	83,492
Intensive Residential Services		43,695	391,993	174,653	610,341
Jail-Based Habilitation Services				150,214	150,214
Supervised Residential Services		252,357	171,106	33,678	457,141
TOTAL Residential Bed Days		315,196	588,703	397,289	1,301,188
Supportive Residential Services		497,927	888,367	18,869	1,405,163
TOTAL Residential Consumer Service Hours		497,927	888,367	18,869	1,405,163
Prevention Services		32,038	5,743	278,833	316,614
Early Intervention Services		32,258	254,434	36,037	322,729
TOTAL Prevention & E.I. Consumer Service Hours		64,296	260,177	314,870	636,343

CONDENSED CORE SERVICES TAXONOMY 7 CSB SERVICE DEFINITIONS (EFFECTIVE JULY 1, 2005)

EMERGENCY SERVICES are unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, 24 hours per day and seven days per week, to people seeking such services for themselves or others. Services also may include walk-ins, home visits, and jail interventions. Emergency Services include preadmission screening or other activities that prevent admission to a mental health hospital or mental retardation training center or are associated with the judicial admission process. This category includes discharge planning for consumers in acute local and state hospital inpatient services. Discharge planning for consumers in state hospital extended rehabilitation services and for Discharge Assistance Project consumers is provided in case management services. Emergency Services also include Medicaid Crisis Intervention and Short-Term Crisis Counseling and Mental Retardation Home and Community-Based (MRHCB) Waiver Crisis Stabilization and Personal Emergency Response System Services.

LOCAL INPATIENT SERVICES deliver services on a 24-hour-per-day basis in a hospital setting.

Acute Psychiatric or Substance Abuse Services provide intensive short-term psychiatric treatment in state hospitals and provide intensive short-term psychiatric treatment, including services to persons with mental retardation, or substance abuse treatment, except detoxification, in local hospitals. Services include intensive stabilization, evaluation, psychotropic medications, psychiatric and psychological services, and other supportive therapies provided in a highly structured and supervised setting.

Community-Based Substance Abuse Medical Detoxification Inpatient Services use medication under the supervision of medical personnel in local hospitals or other 24 hour per day care facilities to systematically eliminate or reduce the effects of alcohol or other drugs in the body.

OUTPATIENT SERVICES provide clinical treatment services, generally in sessions of less than three consecutive hours, to individuals and groups. *Italicized services* not in bold type described in some of the following subcategories are included only for illustrative purposes.

Outpatient Services are generally provided to consumers on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Outpatient Services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Medical services include the provision of psychiatric, medical, psychiatric nursing, and medical nursing services by licensed psychiatrists, physicians, and nurses and the cost of medications purchased by the CSB and provided to consumers. Medication services include prescribing and dispensing medications, medication management, and pharmacy services. Medication only visits include only consumers who receive only medication monitoring on a periodic (monthly or quarterly) basis from a psychiatrist, other MD, psychiatric nurse, or physician's assistant. These visits are included in Outpatient Services. The Department has identified a minimum set of information for licensing purposes that would be needed to constitute an individualized services plan (ISP) for medication only consumers.

Outpatient Services also include ***Intensive Substance Abuse Outpatient Services*** that are provided generally in a concentrated manner over a four to 12 week period for consumers who require intensive outpatient stabilization, such as people with severe psychoactive substance use disorders. Usually, intensive outpatient services include multiple group therapy sessions during the week plus individual and family therapy, consumer monitoring, and case management.

Outpatient Services also include ***Intensive In-home Services*** that are time-limited, usually between two and six months, family preservation interventions for children and adolescents with or at risk of serious emotional disturbance, including such individuals who also have a diagnosis of mental retardation. In-home services are provided typically but not solely in the residence of an individual who is at risk of being moved into or who is being transitioned to home from an out-of-home placement. These services provide crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and 24 hour per day emergency response.

Finally, Outpatient Services also include Medicaid MRHCB Waiver Skilled Nursing Services and Therapeutic

Consultation Services. Probation and Parole and Community Corrections Day Reporting Centers also are included in Outpatient Services, rather than in Limited Services.

Opioid Detoxification Services combine outpatient treatment with administering or dispensing synthetic narcotics, such as methadone, approved by the federal Food and Drug Administration as a substitute for opioid substances, such as heroin or other narcotic drugs, in decreasing doses to reach a drug-free state in a period not to exceed 180 days.

Opioid Treatment Services combine outpatient treatment with administering or dispensing synthetic narcotics, such as methadone, approved by the federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.

Assertive Community Treatment includes two modalities, Intensive Community Treatment (ICT) and Programs of Assertive Community Treatment (PACT). Individuals served by either modality have severe symptoms and impairments that are not effectively remedied by available treatments or, because of reasons related to their mental illnesses, resist or avoid involvement with mental health services. This could include individuals with severe and persistent mental illnesses who also have co-occurring diagnoses of mental retardation. Assertive Community Treatment provides an array of services on a 24-hour per day basis to these individuals in their natural environments to help them achieve and maintain effective levels of functioning and participation in their communities. Services may include case management; supportive counseling; symptom management; medication administration and compliance monitoring; crisis intervention; developing individualized community supports; psychiatric assessment and other services; and teaching daily living, life, social, and communication skills.

Intensive Community Treatment is provided by a self-contained, interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a psychiatrist that (1) assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses; (2) minimally refers individuals to outside service providers; (3) provides services on a long-term care basis with continuity of caregivers over time; (4) delivers 75 percent or more of the services outside of the program's offices; and (5) emphasizes outreach, relationship building, and individualization of services.

Program of Assertive Community Treatment is provided by a self-contained, inter-disciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a psychiatrist that meets the five criteria contained in the definition of *Intensive Community Treatment*.

CASE MANAGEMENT SERVICES assist individuals and their family members to access needed services that are responsive to the person's individual needs. Services include: identifying and reaching out to potential consumers; assessing needs and planning services; linking the individual to services and supports; assisting the person directly to locate, develop or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; and advocating for people in response to their changing needs.

DAY SUPPORT SERVICES provide structured programs of treatment, activity, or training services, generally in clusters of two or more continuous hours per day, to groups or individuals in non-residential settings. *Italicized services* not in bold type described in the following subcategories are included only for illustrative purposes.

Day Treatment/Partial Hospitalization is a treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for adults with serious mental illnesses or substance use disorders who require coordinated, intensive, comprehensive, and multi-disciplinary treatment of pathological conditions that is not provided in outpatient services.

Day Treatment/Partial Hospitalization also includes *Therapeutic Day Treatment for Children and Adolescents*, a treatment program that serves children and adolescents (birth through age 17) with serious emotional disturbances or at risk of serious emotional disturbance in order to combine psychotherapeutic interventions with education and mental health treatment. Services include: evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills, and individual, group, and family counseling.

Rehabilitation/Habilitation includes training opportunities in two modalities.

Psychosocial Rehabilitation provides assessment, medication education, opportunities to learn and use

independent living skills and to enhance social and interpersonal skills, family support and education, vocational and educational opportunities, and advocacy in a supportive community environment focusing on normalization. It emphasizes strengthening the person's abilities to deal with everyday life rather than focusing on treating pathological conditions..

Habilitation provides planned combinations of individualized activities, supports, training, supervision, and transportation to individuals with mental retardation to improve their condition or maintain an optimal level of functioning. Specific components of this service develop or enhance the following skills: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, medication management, and transportation.

Rehabilitation/Habilitation also includes *Alternative Day Support Arrangements* that assist people to locate day support settings and may provide program staff, follow along, or assistance to these individuals with a focus on assisting the person to maintain an independent day support arrangement and *Education/Recreation Services* that provide education, recreation, enrichment, and leisure activities daily, weekly, or monthly, during the summer or throughout the year. Habilitation also includes Medicaid MRHCB Waiver Day Support (Center-Based and Non-Center- Based) and Prevocational Services.

EMPLOYMENT SERVICES provide work and support services to groups or individuals in non-residential settings.

Sheltered Employment programs provide work in a non-integrated setting that is compensated in accordance with the Fair Labor Standards Act for individuals with disabilities who are not ready, are unable, or choose not to enter into competitive employment in an integrated setting. This service includes the development of social, personal, and work-related skills based on an individualized consumer service plan.

Group Supported Employment provides work to small groups of three to eight individuals at job sites in the community or at dispersed sites within an integrated setting. Integrated setting means opportunities exist for consumers in the immediate work setting to have regular contact with non-disabled individuals who are not providing support services. The employer or the vendor of supported employment services employs the consumers. An employment specialist, who may be employed by the employer or the vendor, provides ongoing support services. Support services are provided in accordance with the consumer's individual written rehabilitation plan. Models include mobile and stationary crews, enclaves, and small businesses. Group Supported Employment includes Medicaid MRHCB Waiver Supported Employment - Group Model.

Individual Supported Employment (460) provides paid employment to a consumer placed in an integrated work setting in the community. The employer employs the consumer. On-going support services that may include transportation, job-site training, counseling, advocacy, and any other supports needed to achieve and to maintain the consumer in the supported placement are provided by an employment specialist, co-workers of the supported employee, or other qualified individuals. Support services are provided in accordance with the consumer's individual written rehabilitation plan.

Individual Supported Employment also includes *Transitional Employment* services that involve a sequence of temporary supported placements that result in a final competitive employment placement with or without supports. Service units may be included here or as part of another program, such as psychosocial rehabilitation, depending on how the service is delivered and its relative volume. Individual Supported Employment includes Medicaid MR HCB Waiver Supported Employment - Individual Model.

RESIDENTIAL SERVICES provide overnight care with an intensive treatment or training program in a setting other than a hospital or training center, overnight care with supervised living, or other supportive residential services. Information about numbers of consumers served, units of services, and expenses are projected and reported only at the subcategory level. *Italicized services* not in bold type described in the following subcategories are included only for illustrative purposes.

Highly Intensive Residential Services provide **overnight care with intensive treatment or training services**. These services include: mental health residential treatment centers such as short term intermediate care, crisis stabilization, residential alternatives to hospitalization, and residential services for individuals with dual diagnoses (e.g., mental retardation with co-occurring mental illness) where intensive treatment rather than just supervision occurs and

Intermediate Care Facilities for Mentally Retarded persons (ICF/MR) that deliver active habilitative and training services in a community setting. This subcategory also includes *Community Gero-psychiatric Residential Services* that provide 24-hour non-acute care with treatment in a setting that offers less intensive services than a hospital, but more intensive mental health services than a nursing home or group home. Individuals with mental illness, behavioral problems, and concomitant health problems, usually age 65 and older, who are appropriately treated in a geriatric setting, receive intense supervision, psychiatric care, behavioral treatment planning, nursing, and other health-related services.

Intensive Residential Services provide **overnight care with treatment or training that is less intense than highly intensive residential services**. It includes the following services and Medicaid MRHCB Waiver Congregate Residential Support Services.

Primary Care offers substance abuse rehabilitation services that normally last no more than 30 days. Services include intensive stabilization, daily group therapy and psychoeducation, consumer monitoring, case management, individual and family therapy, and discharge planning.

Intermediate Rehabilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay up to 90 days. Services include supportive group therapy, psycho-education, consumer monitoring, case management, individual and family therapy, employment services, and community preparation services.

Long-Term Habilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay of 90 or more days that provides a highly structured environment where residents, under staff supervision, are responsible for daily operations of the facility. Services include intensive daily group and individual therapy, family counseling, and psycho-education. Daily living skills and employment opportunities are integral components of the treatment program.

Group Homes or Halfway Houses are facilities that provide identified beds and 24 hour supervision for individuals who require training and assistance in basic daily living functions such as meal preparation, personal hygiene, transportation, recreation, laundry, and budgeting. The expected length of stay normally exceeds 30 days.

Jail-Based Habilitation Services offer a substance abuse psychosocial therapeutic community with an expected length of stay of 90 days or more that provides a highly structured environment where residents, under staff and correctional supervision, are responsible for the daily operations of the program. Services include intensive daily group counseling, individual therapy, psycho-educational services, 12 step meetings, discharge planning, and pre-employment and community preparation services. Daily living skills in conjunction with the therapeutic milieu structure are an integral component of the treatment program. Normally, inmates served by this program are housed separately within the jail.

Supervised Residential Services offer **overnight care with supervision and services**. This subcategory includes the following services and Medicaid MRHCB Waiver Congregate Residential Support Services.

Supervised Apartments are directly-operated or contracted, licensed or unlicensed, residential programs that place and provide services to individuals in apartments or other residential settings. The expected length of stay normally exceeds 30 days.

Domiciliary Care provides food, shelter, and assistance in routine daily living but not treatment or training in facilities of five or more beds. This is primarily a long-term setting with an expected length of stay exceeding 30 days. Domiciliary care is less intensive than a group home or supervised apartment; an example would be a licensed assisted living facility (ALF) funded or contracted by a CSB.

Emergency Shelter or Residential Respite programs provide identified beds, supported or controlled by a CSB, in a variety of settings reserved for short term stays, usually several days to no more than 21 consecutive days.

Sponsored Placements place people in residential settings and provide substantial amounts of financial, programmatic, or service support. Examples include individualized therapeutic homes, specialized foster care, family sponsor homes, and residential services contracts for specified individuals. The focus is on individual consumer residential placements with expected lengths of stay exceeding 30 days rather than on organizations with structured staff support and set numbers of beds.

Supportive Residential Services are unstructured services that support individuals in their own housing arrangements. These services normally do not involve overnight care delivered by a program. However, due to the flexible nature of

these services, overnight care may be provided on an hourly basis. It includes the following services and Medicaid MRHCB Waiver Supported Living/In-Home Supports, Respite (Agency and Consumer-Directed) Services, Companion Services (Agency and Consumer-Directed), and Personal Assistance Services (Agency and Consumer-Directed).

In-Home Respite provides care in the homes of people with mental disabilities or in a setting other than that described in residential respite services above. This care may last from several hours to several days and allows the family member care giver to be absent from the home.

Supported Living Arrangements are residential alternatives that are not included in other types of residential services. These alternatives assist people to locate or maintain residential settings where access to beds is not controlled by a CSB and may provide program staff, follow along, or assistance to these individuals. The focus may be on assisting an individual to maintain an independent residential arrangement. Examples include homemaker services, public-private partnerships, and non-CSB subsidized apartments (e.g., HUD certificates).

Housing Subsidies provide cash payments only, with no services or staff support, to enable consumers to live in housing that would otherwise not be accessible to them. These cash subsidies may be used for rent, utility payments, deposits, furniture, and other similar payments required to initiate or maintain housing arrangements for consumers. This is used only for specific allocations of funds from the Department that are earmarked for housing subsidies. Numbers of consumers and expense information should be included in supportive residential services in the contract and reports. Information associated with other housing subsidies should be included in the services of which they are a part.

PREVENTION AND EARLY INTERVENTION SERVICES are designed to prevent or intervene early in the process of mental illness, mental retardation, or substance use disorder, including enhancing the development of handicapped or at-risk infants and toddlers. Activities should not be included in prevention or early intervention services that are really outpatient services to avoid record keeping or licensing requirements, since this exposes the CSB to increased liability and is not clinically appropriate. School-Based Interventions should be included in Prevention, Early Intervention, or Outpatient Services, as appropriate.

Prevention Services involve people, families, communities, and systems working together to promote their strengths and potentials. Prevention is aimed at substantially reducing the incidence of mental illness, mental retardation and other developmental disabilities, and substance use disorders. Emphasis is on enhancement of protective factors and reduction of risk factors. The following six activities comprise prevention services. Information about these activities will be collected and reported separately from the performance contract. Only units of services and expenses at the prevention services level and amounts of funds expended for each of these six activities will be projected and reported through the performance contract process.

Information Dissemination provides awareness and knowledge of the nature and extent of mental illness, mental retardation, developmental disabilities, and substance use disorders. It also provides awareness and knowledge of available prevention programs and services. Examples of information dissemination include media campaigns, public service announcements, informational brochures and materials, community awareness events, and participation on radio or TV talk shows. Information dissemination is characterized by one-way communication from the source to the audience.

Prevention Education aims to affect critical life and social skills, including general competency building, specific coping skills training, support system interventions, strengthening caregivers, and decision-making skills training. Prevention education is characterized by two-way communication with close interaction between the facilitator or educator and the program participants. Examples of prevention education include children of alcoholics groups and parenting classes.

Alternatives provide for the participation of specific populations in activities that are constructive, promote healthy choices, and provide opportunities for skill building. Examples of prevention alternatives include leadership development; community service projects; alcohol, tobacco, and other drug free activities; and youth centers.

Problem Identification and Referral aims at the identification of those individuals who are most at risk of developing problematic behaviors in order to assess if their behaviors can be changed through prevention education. Examples include student and employee assistance programs.

Community-based Process aims at enhancing the ability of the community to provide prevention and treatment services more effectively. Activities include organizing, planning, enhancing efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and networking. Examples include community and volunteer training, multi-agency coordination and collaboration, accessing services and funding, and community team-building.

Environmental prevention activities establish or change written and unwritten community standards, codes, and attitudes, thereby influencing the development of healthy living conditions. Examples include modifying advertising practices and promoting the establishment and review of alcohol, tobacco, and other drug use policies.

Critical Incident Stress Debriefing (CISD) services are also a form of Prevention Services, but they are not included in the preceding activities. Individuals receiving CISD services will not be admitted to the CSB, enrolled in a service, or counted as consumers. Service units will be collected through the z-consumer function in the CCS. Community outreach services, such as outreach contacts with homeless persons, are included in Prevention Services, but these individuals will not be counted as consumers; service units will be collected through the z-consumer function in the CCS.

Early Intervention are intended to improve functioning or change behavior in those individuals identified as beginning to experience problems, symptoms, or behaviors that, without intervention, are likely to result in the need for treatment. Services are generally targeted to identified individuals or groups. Early Intervention Services include: case consultation, groups for adolescents who have been suspended for use of alcohol or tobacco, and programs for children or adults exhibiting behavior changes following loss such as divorce, death of a loved one, and job loss.

Early Intervention Services include *Infant and Toddler Intervention*, which provides family-centered, community-based early intervention services designed to meet the developmental needs of infants and toddlers and the needs of their families as these needs relate to enhancing the child's development. These services prevent or reduce the potential for developmental delays and increase the capacity of families to meet the needs of their at-risk infants and toddlers. Infant and toddler intervention is delivered through a comprehensive, coordinated, interagency, and multi-disciplinary services system. It may include audiology, family training, counseling and home visits, health, medical, nursing, nutrition, occupational therapy, physical therapy, special instruction, psychological, speech-language pathology, vision, and transportation services. The identified consumer is the infant or toddler.

LIMITED SERVICES include the following activities that typically are short term, that is less than 30 days or four to eight sessions in duration, or infrequent or low-intensity services and do not require collection of as many data elements through the CCS or as much consumer service record information as other core services.

Substance Abuse Social Detoxification Services are provided in specialized non-medical facilities with physician services available when required that systematically reduce or eliminate the effects of alcohol or other drugs in the body, return a person to a drug-free state, and normally last up to seven days.

Substance Abuse Motivational Treatment Services are generally provided to consumers on an hourly basis, once per week, through individual or group counseling in a clinic. These services are structured to help consumers resolve their ambivalence about changing problematic behaviors by using a repertoire of data-gathering and feedback techniques. Motivational Treatment Services are not a part of another service; they stand alone. Their singular focus on increasing the consumer's motivation to change problematic behaviors, rather than on changing the behavior itself, distinguishes Motivational Treatment Services from Outpatient Services. A course of motivational treatment may involve a single session, but more typically four or eight sessions; and it may be repeated, if necessary, as long as repetition is clinically indicated. Prior to placement in motivational treatment, the consumer's level of readiness for change is usually assessed, based on clinical judgment, typically supported by standardized instruments. Such an assessment may also follow a course of motivational treatment to ascertain any changes in the consumer's readiness for change.

Consumer Monitoring Services are provided to consumers who have been admitted to the CSB but who will not receive any other services. Individuals who might receive Consumer Monitoring Services include persons who have been admitted to the CSB and assigned a case manager, but they have not been enrolled in another service. Instead, they have been placed on waiting lists for services. These individuals receive no interventions or face-to-face contact in more than 180 days, but they receive Consumer Monitoring Services, which typically consist of service coordination or

intermittent emergency contacts, at least once every 360 days. A consumer who is receiving nothing but family support should be enrolled in Consumer Monitoring. Also included are PATH grant outreach and support services.

Assessment and Evaluation Services include court-ordered or psychological evaluations; initial assessments for screening, triage, and referral for individuals who probably will not continue in services; preadmission screening that does not result in hospitalization; and initial evaluations or assessments that result in placement on waiting lists without receiving other services. An abbreviated individualized services plan and consumer record may be required. Subsequently, if it is determined that an individual needs additional services, he or she would be enrolled in those services.

DEFINITIONS OF STATIC CAPACITIES

Number of Beds: the total number of beds for which the facility or program is licensed and staffed or the number of beds contracted for during the contract period.

Number of Slots: the maximum number of distinct consumers who could be served during a day or a half-day session in most day support programs. It is the number of slots for which the program or service is staffed.

Consumers: the number of consumers will always be the total number of consumers served during the reporting period. The following definitions are used to determine at what point in time an individual is counted as a consumer.

Emergency: upon documented face-to-face contact or telephone contacts during which a person receives counseling.

Inpatient: upon physical residence in the program.

Outpatient and Case Management: upon initial documented face-to-face contact for people for whom a record would normally be opened. For case management services, face-to-face contact is not necessary if records are obtained, a file is opened, and extensive preliminary work is done for a consumer before it is feasible to meet the consumer in a face-to-face situation.

Day Support: upon initial documented attendance or participation in the program, or, for supported employment and alternative day support, upon initial documented face-to-face contact for persons for whom a record would normally be opened.

Residential: upon physical residence in the program, or, for supported services, upon initial documented face-to-face contact for individuals for whom a record would normally be opened.

Early Intervention: upon initial documented attendance or participation in early intervention programs, including infant and toddler intervention.

Appendix D
State Mental Health and Mental Retardation Facility Utilization
State Mental Health Facility Patients Served, Average Daily Census, Admissions, and Separations -- FY 2005

MH Facility	# Patients Served	Average Daily Census	# Admissions	# Separations
Eastern State Hospital	808	409	437	443
Western State Hospital	893	243	748	742
Central State Hospital	816	244	648	649
Southwestern VA MHI	1,213	143	1,325	1,318
Northern VA MHI	482	123	424	421
Southern VA MHI	469	69	517	509
Commonwealth Center for Children and Adolescents	482	29	537	538
Catawba Hospital	487	100	491	496
Piedmont Geriatric Hospital	223	118	105	120
Hiram Davis Medical Center	173	67	151	148
Total MH	5,896*	1,545	5,383	5,384

Virginia Center for Behavioral Rehabilitation Residents Served, Average Daily Census, Admissions, and Separations -- FY2005

	# Residents Served	Average Daily Census	# Admissions	# Separations
VCBR	17*	12	8	1

State Mental Retardation Training Center Residents Served, Average Daily Census, Admissions, and Separations -- FY2005

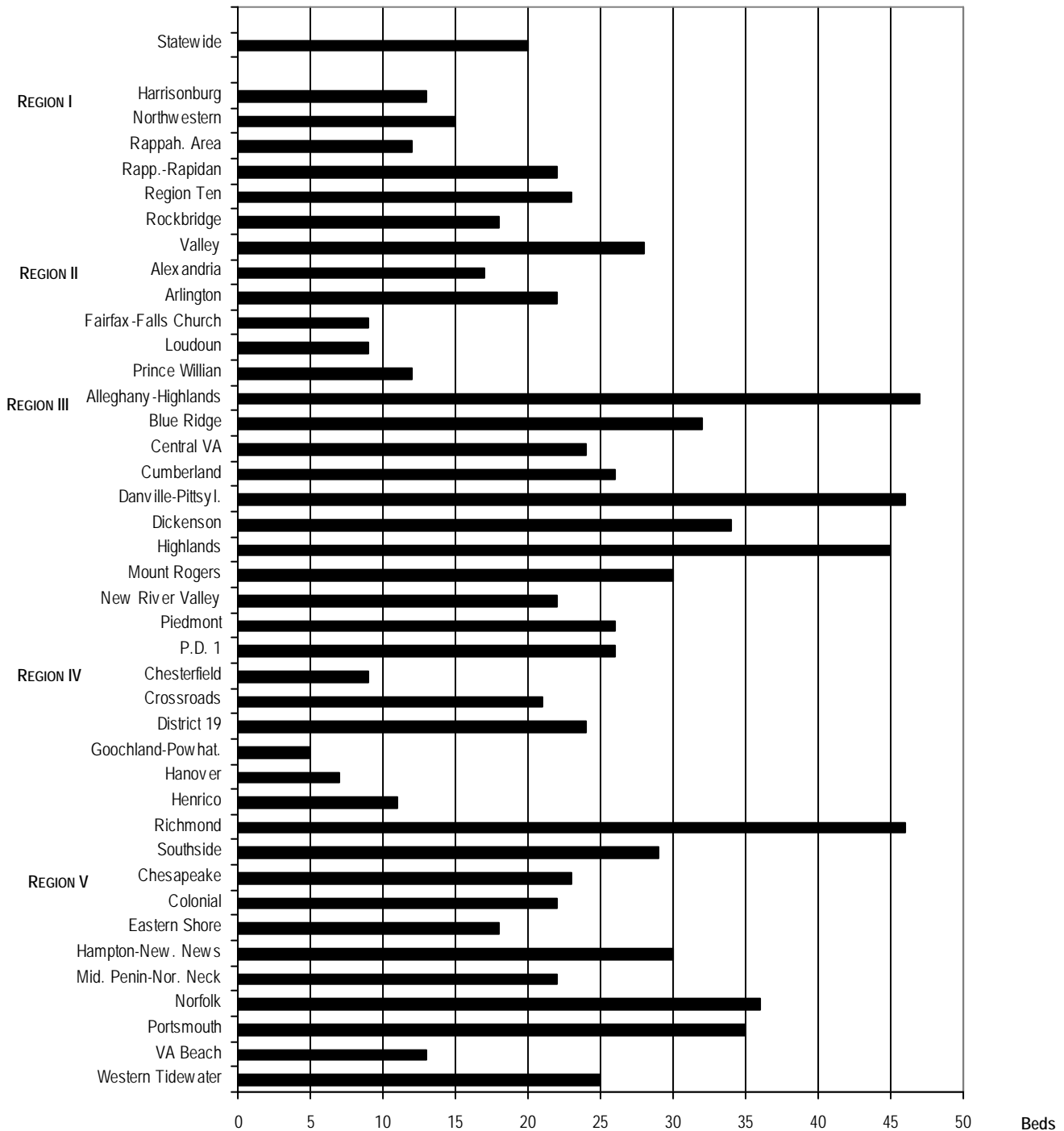
MR Training Center	# Residents Served	Average Daily Census	# Admissions	# Separations
Central Virginia TC	589	564	10	32
Northern Virginia TC	205	182	52	53
Southeastern Virginia TC	205	193	6	10
Southside Virginia TC	411	371	22	49
Southwestern Virginia TC	236	214	24	30
Total MR	1,646*	1,524	114	174

Source: DMHMRSAS AVATAR Information System

*Unduplicated count for by state facility type. Totally unduplicated count across all state facilities: 7,427

Total State Mental Health Facility Bed Utilization by CSB and Region **FY 2004**

Beds Per 100,000 Population



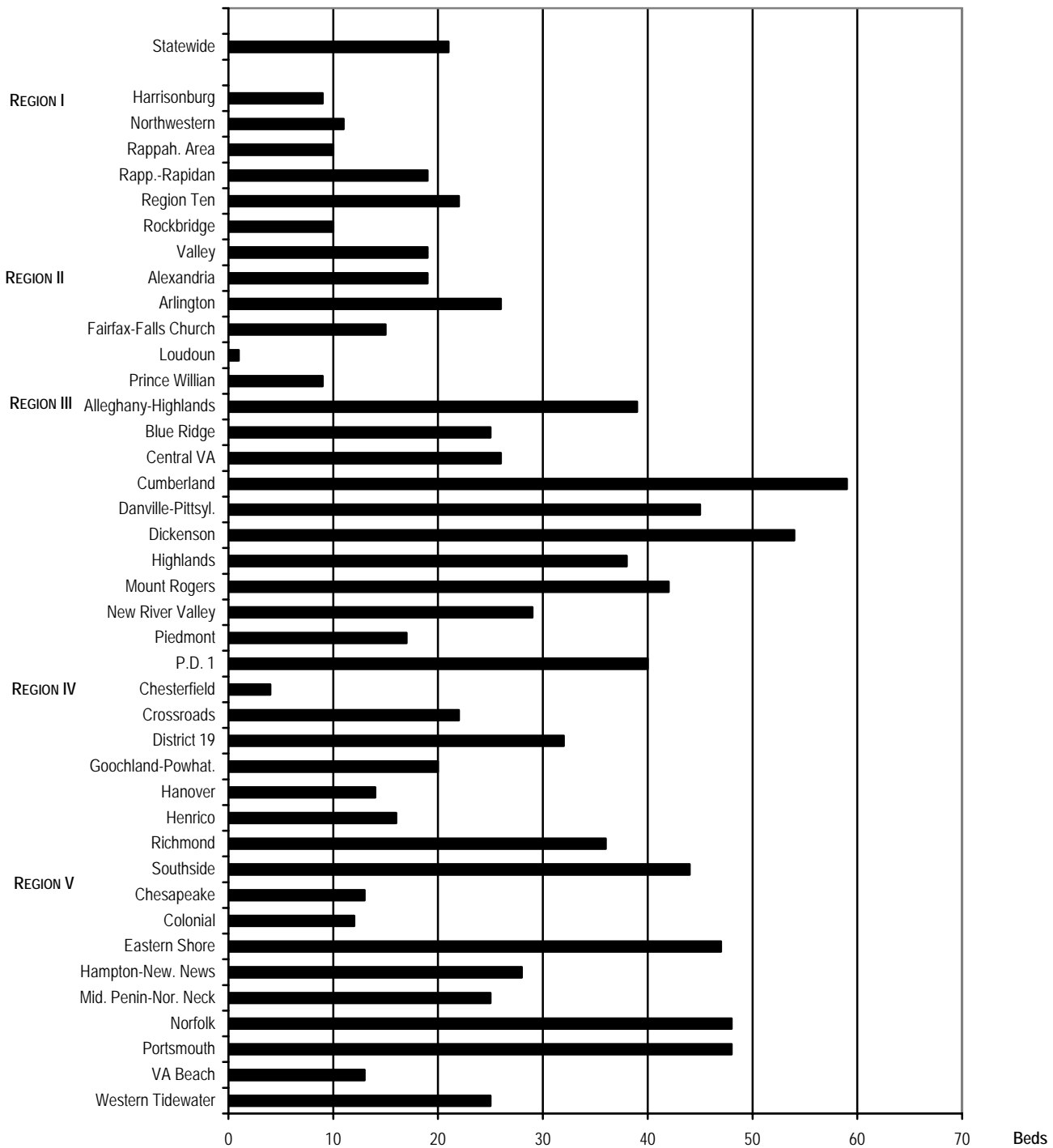
Total State Mental Health Facility Utilization by CSB and Region -- FY2004

	CSB	All Bed Days FY 2004	Population	FY 2004 Bed Days Per 100 K Population	FY 2004 Beds Per 100 K Population	Beds Used
I	Harrisonburg-Rockingham	5,328	112,200	4,749	12.97	14.56
	Northwestern	10,540	197,500	5,337	14.58	28.80
	Rappahannock Area	11,781	279,100	4,221	11.53	32.19
	Rappahannock-Rapidan	11,868	145,200	8,174	22.33	32.43
	Region Ten	17,746	209,400	8,475	23.15	48.49
	Rockbridge Area	2,528	39,000	6,482	17.71	6.91
	Valley	11,376	111,400	10,212	27.90	31.08
II	Alexandria	8,422	134,100	6,280	17.16	23.01
	Arlington	15,602	193,700	8,055	22.01	42.63
	Fairfax-Falls Church	33,878	1,037,400	3,266	8.92	92.56
	Loudoun County	6,848	224,500	3,050	8.33	18.71
	Prince William County	15,953	377,900	4,221	11.53	43.59
III	Alleghany Highlands	3,934	23,000	17,104	46.73	10.75
	Blue Ridge	27,853	241,400	11,538	31.52	76.10
	Central Virginia	20,098	230,100	8,734	23.86	54.91
	Cumberland Mountain	9,376	98,700	9,499	25.95	25.62
	Danville-Pittsylvania	18,094	107,700	16,800	45.90	49.44
	Dickenson County	2,042	16,200	12,605	34.44	5.58
	Highlands	11,188	68,500	16,333	44.63	30.57
	Mount Rogers	13,185	119,700	11,015	30.10	36.02
	New River Valley	13,107	165,000	7,944	21.70	35.81
	Piedmont	13,405	138,700	9,665	26.41	36.63
	Planning District 1	8,852	93,100	9,508	25.98	24.19
IV	Chesterfield	8,811	275,400	3,199	8.74	24.07
	Crossroads	7,550	98,300	7,681	20.99	20.63
	District 19	15,110	169,100	8,936	24.41	41.28
	Goochland-Powhatan	737	43,200	1,706	4.66	2.01
	Hanover County	2,503	92,800	2,697	7.37	6.84
	Henrico Area	11,927	296,100	4,028	11.01	32.59
	Richmond BHA	32,864	193,900	16,949	46.31	89.79
	Southside	9,125	87,000	10,489	28.66	24.93
V	Chesapeake	17,653	206,600	8,545	23.35	48.23
	Colonial	10,879	137,700	7,901	21.59	29.72
	Eastern Shore	3,317	51,500	6,441	17.60	9.06
	Hampton-Newport News	35,369	324,900	10,886	29.74	96.64
	Middle Peninsula-Northern Neck	10,809	135,000	8,007	21.88	29.53
	Norfolk	31,225	233,900	13,350	36.47	85.31
	Portsmouth	12,597	97,900	12,867	35.16	34.42
	Virginia Beach	20,209	428,200	4,720	12.89	55.22
	Western Tidewater	11,710	129,100	9,070	24.78	31.99
	Out of State/Unknown/Unassigned	3,761	0	0	0	10.27
	VIRGINIA STATEWIDE	539,160	7,364,100	7,321.46	20.00	1,473.11

Source: DMHMRSAS PRAIS and 2003 Final Estimated Population, Weldon Cooper Center for Public Service, UVA.
Note: Excludes HRMC and VCBR

Mental Retardation Training Center Bed Utilization by CSB and Region FY 2004

Beds Per 100,000 Population



State Training Center Utilization by CSB and Region -- FY 2004

	CSB	All Bed Days FY 2004	Population	FY 2004 Bed Days Per 100 K Population	FY 2004 Beds Per 100 K Population	Beds Used
I	Harrisonburg-Rockingham	3,638	112,200	3,242	8.86	9.94
	Northwestern	8,230	197,500	4,167	11.39	22.49
	Rappahannock Area	9,842	279,100	3,526	9.63	26.89
	Rappahannock-Rapidan	10,058	145,200	6,927	18.93	27.48
	Region Ten	16,684	209,400	7,968	21.77	45.58
	Rockbridge Area	1,460	39,000	3,744	10.23	3.99
	Valley	7,787	111,400	6,990	19.10	21.28
II	Alexandria	9,137	134,100	6,814	18.62	24.96
	Arlington	18,114	193,700	9,352	25.55	49.49
	Fairfax-Falls Church	56,217	1,037,400	5,419	14.81	153.60
	Loudoun County	365	224,500	163	0.44	1.00
	Prince William County	12,331	377,900	3,263	8.92	33.69
III	Alleghany Highlands	3,313	23,000	14,404	39.36	9.05
	Blue Ridge	22,295	241,400	9,236	25.23	60.92
	Central Virginia	21,641	230,100	9,405	25.70	59.13
	Cumberland Mountain	21,235	98,700	21,515	58.78	58.02
	Danville-Pittsylvania	17,619	107,700	16,359	44.70	48.14
	Dickenson County	3,227	16,200	19,920	54.43	8.82
	Highlands	9,649	68,500	14,086	38.49	26.36
	Mount Rogers	18,329	119,700	15,312	41.84	50.08
	New River Valley	17,387	165,000	10,538	28.79	47.51
	Piedmont	8,349	138,700	6,019	16.45	22.81
	Planning District 1	13,441	93,100	14,437	39.45	36.72
IV	Chesterfield	3,943	275,400	1,432	3.91	10.77
	Crossroads	7,926	98,300	8,063	22.03	21.66
	District 19	19,562	169,100	11,568	31.61	53.45
	Goochland-Powhatan	3,160	43,200	7,315	19.99	8.63
	Hanover County	4,669	92,800	5,031	13.75	12.76
	Henrico Area	17,430	296,100	5,887	16.08	47.62
	Richmond BHA	25,811	193,900	13,312	36.37	70.52
	Southside	13,985	87,000	16,075	43.92	38.21
V	Chesapeake	9,477	206,600	4,587	12.53	25.89
	Colonial	6,007	137,700	4,362	11.92	16.41
	Eastern Shore	8,792	51,500	17,072	46.64	24.02
	Hampton-Newport News	33,036	324,900	10,168	27.78	90.26
	Middle Peninsula-Northern Neck	12,289	135,000	9,103	24.87	33.58
	Norfolk	41,087	233,900	17,566	47.99	112.26
	Portsmouth	17,131	97,900	17,498	47.81	46.81
	Virginia Beach	19,962	428,200	4,662	12.74	54.54
	Western Tidewater	11,894	129,100	9,213	25.17	32.50
Out of State		1,093	0	0	0	2.99
	VIRGINIA STATEWIDE	567,602	7,364,100	7,707.69	21.06	1,550.83

Source: DMHMRSAS PRAIS and 2003 Final Estimated Population, Weldon Cooper Center for Public Service, UVA.

**State Mental Health and Mental Retardation Facility Numbers of Admissions, Separations and
Average Daily Census
FY 1976 to FY 2005**

	State Mental Health Facilities*			State Mental Retardation Training Centers**		
	Number of Admissions	Number of Separations	Average Daily Census	Number of Admissions	Number of Separations	Average Daily Census
FY 1976	10,319	10,943	5,967	250	639	4,293
FY 1977	10,051	10,895	5,489	418	618	3,893
FY 1978	10,641	11,083	5,218	277	404	3,790
FY 1979	10,756	10,926	5,112	299	416	3,701
FY 1980	10,513	11,345	4,835	296	428	3,576
FY 1981	10,680	11,513	4,486	252	399	3,467
FY 1982	10,212	10,616	4,165	205	301	3,391
FY 1983	10,030	10,273	3,798	162	232	3,309
FY 1984	9,853	10,163	3,576	194	322	3,189
FY 1985	9,456	9,768	3,279	197	314	3,069
FY 1986	8,942	9,077	3,110	172	280	2,970
FY 1987	8,919	8,900	3,004	165	238	2,892
FY 1988	9,549	9,637	3,047	143	224	2,828
FY 1989	9,591	9,605	3,072	146	231	2,761
FY 1990	9,249	9,293	2,956	110	181	2,676
FY 1991	9,323	9,519	2,904	107	162	2,626
FY 1992	9,057	9,245	2,775	116	215	2,548
FY 1993	8,560	8,651	2,588	94	192	2,481
FY 1994	9,187	9,317	2,482	106	193	2,375
FY 1995	8,550	8,774	2,348	87	216	2,249
FY 1996	7,468	7,529	2,222	87	223	2,132
FY 1997	7,195	7,257	2,118	77	210	1,987
FY 1998	7,431	7,522	2,089	78	170	1,890
FY 1999	6,210	6,449	1,914	106	188	1,812
FY 2000	5,069	5,233	1,694	101	194	1,749
FY 2001	5,223	5,176	1,641	101	156	1,680
FY 2002	5,936	5,915	1,654	122	177	1,618
FY 2003	5,946	6,008	1,609	95	132	1,581
FY 2004	5,382	5,599	1,588	73	114	1,568
FY 2005	5,232	5,236	1,478	114	174	1,524

* Excludes Hiram Davis Medical Center and the Virginia Center for Behavioral Rehabilitation. Includes the Virginia Treatment Center for Children (VTCC) through FY 91 when the VTCC was transferred to MCV.

** Operations at SVTC began in 1971, NVTC began in 1973, SWVTC in 1973, and SEVTC began in 1975.

Appendix E

Prevalence Estimates by CSB

Estimated Prevalence of Serious Mental Illness by CSB and Region

	CSB	Population Age 18 + (2003 Est.)	Est. Population with SMI (5.4%)	Lower Limit of SMI Estimate (3.7%)	Upper Limit of SMI Estimate (7.1%)
I	Harrisonburg-Rockingham	84,150	4,544	3,114	5,975
	Northwestern	148,125	7,999	5,481	10,517
	Rappahannock Area	209,325	11,304	7,745	14,862
	Rappahannock-Rapidan	108,900	5,881	4,029	7,732
	Region Ten	157,050	8,481	5,811	11,151
	Rockbridge Area	29,250	1,580	1,082	2,077
	Valley	83,550	4,512	3,091	5,932
II	Alexandria	100,575	5,431	3,721	7,141
	Arlington	145,275	7,845	5,375	10,315
	Fairfax-Falls Church	778,050	42,015	28,788	55,242
	Loudoun County	168,375	9,092	6,230	11,955
	Prince William County	283,425	15,305	10,487	20,123
III	Alleghany Highlands	17,250	932	638	1,225
	Blue Ridge	181,050	9,777	6,699	12,855
	Central Virginia	172,575	9,319	6,385	12,253
	Cumberland Mountain	74,025	3,997	2,739	5,256
	Danville-Pittsylvania	80,775	4,362	2,989	5,735
	Dickenson County	12,150	656	450	863
	Highlands	51,375	2,774	1,901	3,648
	Mount Rogers	89,775	4,848	3,322	6,374
	New River Valley	123,750	6,683	4,579	8,786
	Piedmont	104,025	5,617	3,849	7,386
	Planning District 1	69,825	3,771	2,584	4,958
IV	Chesterfield	206,550	11,154	7,642	14,685
	Crossroads	73,725	3,981	2,728	5,234
	District 19	126,825	6,849	4,693	9,005
	Goochland-Powhatan	32,400	1,750	1,199	2,300
	Hanover County	69,600	3,758	2,575	4,942
	Henrico Area	222,075	11,992	8,217	15,767
	Richmond BHA.	145,425	7,853	5,381	10,325
	Southside	65,250	3,524	2,414	4,633
V	Chesapeake	154,950	8,367	5,733	11,001
	Colonial	103,275	5,577	3,821	7,333
	Eastern Shore	38,625	2,086	1,429	2,742
	Hampton-Newport News	243,675	13,158	9,016	17,301
	Middle Peninsula-Northern Neck	101,250	5,468	3,746	7,189
	Norfolk	175,425	9,473	6,491	12,455
	Portsmouth	73,425	3,965	2,717	5,213
	Virginia Beach	321,150	17,342	11,883	22,802
	Western Tidewater	96,825	5,229	3,583	6,875
	TOTAL	5,523,075	298,246	204,354	392,138

Population cohort age 18 and over is 75% of the total population.

**Estimated Prevalence of Child/Adolescent Serious Emotional Disturbance
by CSB and Region**

	CSB	Population Age 9-17 (2003 Estimate)	Est. SED, Level of Functioning Score = 50		Estimated SED, Level of Functioning Score = 60	
			Lower	Upper	Lower	Upper
I	Harrisonburg-Rockingham	14,070	844	1,126	1,407	1,688
	Northwestern	24,767	1,486	1,981	2,477	2,972
	Rappahannock Area	34,999	2,100	2,800	3,500	4,200
	Rappahannock-Rapidan	18,208	1,092	1,457	1,821	2,185
	Region Ten	26,259	1,576	2,101	2,626	3,151
	Rockbridge Area	4,891	293	391	489	587
	Valley	13,970	838	1,118	1,397	1,676
II	Alexandria	16,816	1,009	1,345	1,682	2,018
	Arlington	24,290	1,457	1,943	2,429	2,915
	Fairfax-Falls Church	130,090	7,805	10,407	13,009	15,611
	Loudoun County	28,152	1,689	2,252	2,815	3,378
	Prince William County	47,389	2,843	3,791	4,739	5,687
III	Alleghany Highlands	2,884	173	231	288	346
	Blue Ridge	30,272	1,816	2,422	3,027	3,633
	Central Virginia	28,855	1,731	2,308	2,885	3,463
	Cumberland Mountain	12,377	743	990	1,238	1,485
	Danville-Pittsylvania	13,506	810	1,080	1,351	1,621
	Dickenson	2,031	122	163	203	244
	Highlands	8,590	515	687	859	1,031
	Mount Rogers	15,010	901	1,201	1,501	1,801
	New River Valley	20,691	1,241	1,655	2,069	2,483
	Piedmont	17,393	1,044	1,391	1,739	2,087
	Planning District 1	11,675	700	934	1,167	1,401
IV	Chesterfield	34,535	2,072	2,763	3,454	4,144
	Crossroads	12,327	740	986	1,233	1,479
	District 19	21,205	1,272	1,696	2,121	2,545
	Goochland-Powhatan	5,417	325	433	542	650
	Hanover County	11,637	698	931	1,164	1,396
	Henrico Area	37,131	2,228	2,970	3,713	4,456
	Richmond BHA	24,315	1,459	1,945	2,432	2,918
	Southside	10,910	655	873	1,091	1,309
V	Chesapeake	25,908	1,554	2,073	2,591	3,109
	Colonial	17,268	1,036	1,381	1,727	2,072
	Eastern Shore	6,458	387	517	646	775
	Hampton-Newport News	40,742	2,445	3,259	4,074	4,889
	Middle Peninsula-Northern Neck	16,929	1,016	1,354	1,693	2,031
	Norfolk	29,331	1,760	2,346	2,933	3,520
	Portsmouth	12,277	737	982	1,228	1,473
	Virginia Beach	53,696	3,222	4,296	5,370	6,444
	Western Tidewater	16,189	971	1,295	1,619	1,943
	TOTAL	923,458	55,407	73,877	92,346	110,815

Population cohort age 9 to 17 is 12.54% of the total population.

LOF = 50: lower 6%, upper 8%; LOF = 60: lower 10%, upper 12%.

Estimated Prevalence of Mental Retardation by CSB and Region

	CSB	Population Age 6 + (2003 Est.)	Estimated # with MR (Age 6 and Over)	Population Age 0 to 5 (2003 Est.)	Estimated # of Infants/Toddlers with DD (Age 0-5)
I	Harrisonburg-Rockingham	102,809	1,028	9,200	276
	Northwestern	180,969	1,810	16,195	486
	Rappahannock Area	255,739	2,557	22,886	687
	Rappahannock-Rapidan	133,047	1,330	11,906	357
	Region Ten	191,873	1,919	17,171	515
	Rockbridge Area	35,736	357	3,198	96
	Valley	102,076	1,021	9,135	274
II	Alexandria	122,876	1,229	10,996	330
	Arlington	177,487	1,775	15,883	477
	Fairfax-Falls Church	950,570	9,506	85,067	2,552
	Loudoun County	205,709	2,057	18,409	552
	Prince William County	346,270	3,463	30,988	930
III	Alleghany Highlands	21,075	211	1,886	57
	Blue Ridge	221,15	2,212	19,795	594
	Central Virginia	210,841	2,108	18,868	566
	Cumberland Mountain	90,439	904	8,093	243
	Danville-Pittsylvania	98,686	987	8,831	265
	Dickenson	14,844	148	1,328	40
	Highlands	62,767	628	5,617	169
	Mount Rogers	109,681	1,097	9,815	294
	New River Valley	151,190	1,512	13,530	406
	Piedmont	127,091	1,271	11,373	341
	Planning District 1	85,308	853	7,634	229
IV	Chesterfield	252,349	2,523	22,483	677
	Crossroads	90,072	901	8,061	242
	District 19	154,946	1,549	13,866	416
	Goochland-Powhatan	39,584	396	3,542	106
	Hanover County	85,033	850	7,610	228
	Henrico Area	271,316	2,713	24,280	728
	Richmond BHA	177,671	1,777	15,900	477
	Southside	79,718	797	7,134	214
V	Chesapeake	189,308	1,893	16,941	508
	Colonial	126,175	1,262	11,291	339
	Eastern Shore	47,189	472	4,223	127
	Hampton-Newport News	297,706	2,977	26,642	799
	Middle Peninsula-Northern Neck	123,701	1,237	11,070	332
	Norfolk	214,323	2,143	19,180	575
	Portsmouth	89,706	897	8,028	241
	Virginia Beach	392,360	3,924	35,112	1,053
	Western Tidewater	118,294	1,183	10,586	318
	TOTAL	6,747,725	67,477	603,856	18,116

Population cohort age 0-5 is 8.2%. Estimated 3% of children 0-5 have a developmental disability or delay.
Population cohort age 6+ is 91.63% of the total population.

Estimated Prevalence of Drug and Alcohol Dependence by CSB and Region

	CSB	Population 12+ 2003 Estimate	Estimated # Drug Dependence	Estimated # Alcohol Dependence	Total Est. # Drug & Alcohol Depend.*
I	Harrisonburg-Rockingham	93,463	1,860	3,252	5,112
	Northwestern	164,518	3,274	5,725	8,999
	Rappahannock Area	232,490	4,627	8,091	12,718
	Rappahannock-Rapidan	120,952	2,407	4,209	6,616
	Region Ten	174,430	3,471	6,070	9,541
	Rockbridge Area	32,487	646	1,131	1,777
	Valley	92,796	1,847	3,229	5,076
II	Alexandria	111,705	2,223	3,887	6,110
	Arlington	161,352	3,211	5,615	8,826
	Fairfax-Falls Church	864,154	17,197	30,073	47,270
	Loudoun County	187,009	3,721	6,508	10,229
	Prince William County	314,791	6,264	10,955	17,219
III	Alleghany Highlands	19,159	381	667	1,048
	Blue Ridge	201,086	4,002	6,998	11,000
	Central Virginia	191,673	3,814	6,670	10,484
	Cumberland Mountain	82,217	1,636	2,861	4,497
	Danville-Pittsylvania	89,714	1,785	3,122	4,907
	Dickenson County	13,495	269	470	739
	Highlands	57,061	1,136	1,986	3,122
	Mount Rogers	99,710	1,984	3,470	5,454
	New River Valley	137,445	2,735	4,783	7,518
	Piedmont	115,537	2,299	4,021	6,320
	Planning District 1	77,552	1,543	2,699	4,242
IV	Chesterfield	229,408	4,565	7,983	12,548
	Crossroads	81,884	1,629	2,850	4,479
	District 19	140,860	2,803	4,902	7,705
	Goochland-Powhatan	35,986	716	1,252	1,968
	Hanover County	77,302	1,538	2,690	4,228
	Henrico Area	246,651	4,908	8,583	13,491
	Richmond BHA	161,519	3,214	5,621	8,835
	Southside	72,471	1,442	2,522	3,964
V	Chesapeake	172,098	3,425	5,989	9,414
	Colonial	114,704	2,283	3,992	6,275
	Eastern Shore	42,900	854	1,493	2,347
	Hampton-Newport News	270,642	5,386	9,418	14,804
	Middle Peninsula-Nor. Neck	112,455	2,238	3,913	6,151
	Norfolk	194,839	3,877	6,780	10,657
	Portsmouth	81,551	1,623	2,838	4,461
	Virginia Beach	356,691	7,098	12,413	19,511
	Western Tidewater	107,540	2,140	3,742	5,882
	TOTAL	6,134,296	122,072	213,473	335,545

*Note: Total includes a duplicated count of persons with co-occurring drug and alcohol dependence.
Population cohort age 12 and over is 83.3% of the total population.

Appendix F
Individuals on Waiting Lists for CSB Services by CSB
Adults on CSB Mental Health Services Waiting Lists -- January - April 2005

	CSB	Adult SMI Prevalence	Unduplicated # Served (FY2004 4 th Quarter Rept.)		On CSB Waiting Lists		Total on CSB Waiting List
			# Served	# SMI	Receiving CSB Services	Not Receiving Some CSB Services	
I	Harrisonburg-Rockingham	4,544	1,237	905	62	0	62
	Northwestern	7,999	2,143	1,540	202	55	257
	Rappahannock Area	11,304	2,470	1,213	62	82	144
	Rappahannock-Rapidan	5,881	2,072	1,194	107	4	111
	Region Ten	8,481	2,386	1,085	45	3	48
	Rockbridge	1,580	858	359	0	0	0
	Valley	4,512	1,902	960	0	0	0
II	Alexandria	5,431	2,194	979	168	25	193
	Arlington	7,845	2,216	1,205	21	0	21
	Fairfax-Falls Church	42,015	8,783	3,842	361	122	483
	Loudoun	9,092	1,892	736	50	2	52
	Prince William	15,305	2,213	645	39	18	57
III	Alleghany-Highlands	932	534	281	12	0	12
	Blue Ridge	9,777	3,059	1,794	52	10	62
	Central Virginia	9,319	2,987	1,684	57	10	67
	Cumberland Mountain	3,997	1,656	1,096	82	17	99
	Danville-Pittsylvania	4,362	1,624	735	66	5	71
	Dickenson County	656	592	417	0	0	0
	Highlands	2,774	2,259	786	83	8	91
	Mount Rogers	4,848	2,692	1,993	673	9	682
	New River Valley	6,683	1,965	999	74	52	126
	Piedmont	5,617	2,267	1,471	31	31	62
	P.D. 1	3,771	2,474	1,496	179	5	184
IV	Chesterfield	11,154	1,630	1,145	104	24	128
	Crossroads	3,981	1,627	1,035	31	64	95
	District 19	6,849	2,100	1,181	19	22	41
	Goochland-Powhatan	1,750	309	202	30	0	30
	Hanover	3,758	1,679	391	80	1	81
	Henrico	11,992	2,498	1,203	197	3	200
	Richmond BHA	7,853	3,659	1,734	63	41	104
	Southside	3,524	1,338	697	11	12	23
V	Chesapeake	8,367	1,474	839	26	0	26
	Colonial	5,577	1,513	638	31	57	88
	Eastern Shore	2,086	864	490	0	3	3
	Hampton-Newport News	13,158	4,552	2,166	0	0	0
	Middle Pen.-Northern Neck	5,468	2,097	1,041	122	69	191
	Norfolk	9,473	2,187	1,244	87	1	88
	Portsmouth	3,965	1,384	902	17	0	17
	Virginia Beach	17,342	2,132	1,550	230	54	284
	Western Tidewater	5,229	1,448	701	80	2	82
	TOTAL	298,246	84,966	44,574	3,554	811	4,365

Children and Adolescents on CSB Mental Health Services Waiting Lists -- January - April 2005

	CSB	SED Prevalence (LOF = 50 Upper Range)	Unduplicated # Served (FY 2004 4 th Quarter Rept.)		On CSB Waiting Lists		Total on CSB Waiting List
			# Served	# SED	Receiving CSB Services	Not Receiving Some CSB Services	
I	Harrisonburg-Rockingham	1,126	325	259	33	4	37
	Northwestern	1,981	679	454	21	144	165
	Rappahannock Area	2,800	807	458	27	57	84
	Rappahannock-Rapidan	1,457	638	381	17	0	17
	Region Ten	2,101	784	336	4	3	7
	Rockbridge	391	229	114	0	0	0
	Valley	1,118	483	237	0	0	0
II	Alexandria	1,345	353	158	7	4	11
	Arlington	1,943	105	33	11	5	16
	Fairfax-Falls Church	10,407	1,858	544	64	20	84
	Loudoun	2,252	774	225	11	1	12
	Prince William	3,791	687	248	7	17	24
III	Alleghany-Highlands	231	133	66	3	1	4
	Blue Ridge	2,422	875	360	26	7	33
	Central Virginia	2,308	1,658	1,082	142	38	180
	Cumberland Mountain	990	573	450	258	8	266
	Danville-Pittsylvania	1,080	266	80	14	10	24
	Dickenson County	163	114	92	0	0	0
	Highlands	687	529	171	4	3	7
	Mount Rogers	1,201	588	394	122	7	129
	New River Valley	1,655	753	444	25	1	26
	Piedmont	1,391	872	609	47	10	57
	P.D. 1	934	1,064	632	59	1	60
IV	Chesterfield	2,763	418	261	109	28	137
	Crossroads	986	589	365	16	43	59
	District 19	1,696	472	142	2	1	3
	Goochland-Powhatan	433	90	61	3	0	3
	Hanover	931	686	211	29	0	29
	Henrico	2,970	916	464	80	17	97
	Richmond BHA	1,945	1,209	766	20	55	75
	Southside	873	355	183	1	8	9
V	Chesapeake	2,073	196	116	3	0	3
	Colonial	1,381	279	102	17	18	35
	Eastern Shore	517	320	194	0	0	0
	Hampton-Newport News	3,259	1,706	940	57	14	71
	Middle Pen.-Northern Neck	1,354	671	353	76	57	133
	Norfolk	2,346	183	69	20	33	53
	Portsmouth	982	213	152	0	0	0
	Virginia Beach	4,296	393	207	42	8	50
	Western Tidewater	1,295	366	112	0	2	2
	TOTAL	73,877	24,209	12,525	1,377	625	2,002

Individuals on CSB Mental Retardation Services Waiting Lists -- January - April 2005

	CSB	MR Prevalence Age 6 and Over	Infant & Toddler DD Prevalence Age 0-5	Unduplicated # Served (FY 2004 4 th Quarter Report)	On CSB Waiting Lists		Total on CSB Waiting List
					Receiving CSB Services	Not Receiving Some CSB Services	
I	Harrisonburg-Rockingham	1,028	276	364	102	15	117
	Northwestern	1,810	486	628	236	21	257
	Rappahannock Area	2,557	687	907	163	34	197
	Rappahannock-Rapidan	1,330	357	400	52	6	58
	Region Ten	1,919	515	638	157	2	159
	Rockbridge	357	96	268	40	0	40
	Valley	1,021	274	540	198	2	200
II	Alexandria	1,229	330	465	51	8	59
	Arlington	1,775	477	268	56	70	126
	Fairfax-Falls Church	9,506	2,552	2,774	432	291	723
	Loudoun	2,057	552	695	88	56	144
	Prince William	3,463	930	1,160	93	16	109
III	Alleghany-Highlands	211	57	190	5	3	8
	Blue Ridge	2,212	594	742	111	23	134
	Central Virginia	2,108	566	822	76	0	76
	Cumberland Mountain	904	243	444	36	2	38
	Danville-Pittsylvania	987	265	378	34	23	57
	Dickenson County	148	40	37	0	0	0
	Highlands	628	169	326	23	4	27
	Mount Rogers	1,097	294	644	198	10	208
	New River Valley	1,512	406	348	14	17	31
	Piedmont	1,271	341	398	44	9	53
	P.D. 1	853	229	453	26	13	39
IV	Chesterfield	2,523	677	1,229	808	2	810
	Crossroads	901	242	195	23	32	55
	District 19	1,549	416	495	25	45	70
	Goochland-Powhatan	396	106	156	6	4	10
	Hanover	850	228	439	150	3	153
	Henrico	2,713	728	1,026	198	2	200
	Richmond Behavioral	1,777	477	1,110	168	0	168
	Southside	797	214	260	20	2	22
V	Chesapeake	1,893	508	608	55	1	56
	Colonial	1,262	339	376	35	24	59
	Eastern Shore	472	127	290	10	5	15
	Hampton-Newport News	2,977	799	495	132	45	177
	Middle Pen.-Northern Neck	1,237	332	502	46	17	63
	Norfolk	2,143	575	890	172	17	189
	Portsmouth	897	241	437	26	22	48
	Virginia Beach	3,924	1,053	1,028	87	87	174
	Western Tidewater	1,183	318	500	40	5	45
	TOTAL	67,477	18,116	23,925	4,236	938	5,174

Adults and Adolescents on CSB Substance Abuse Services Waiting Lists -- January - April 2005

	CSB	Drug & Alcohol Dependence Prevalence	Unduplicated # Served (FY 2004 4 th Qtr. Rept.)	On CSB Waiting Lists				Totals on CSB Adult and Adolescent Waiting Lists		
				Receiving CSB Services	Not Receiving Some CSB Services	Adult	Adol.	Adult	Adol.	Total
I	Harrisonburg-Rockingham	5,112	567	20	1	2	0	22	1	23
	Northwestern	8,999	826	42	9	0	8	42	17	59
	Rappahannock Area	12,718	2685	9	3	26	3	35	6	41
	Rappahannock-Rapidan	6,616	839	28	0	2	0	30	0	30
	Region Ten	9,541	1,725	3	1	8	0	11	1	12
	Rockbridge	1,777	351	0	0	0	0	0	0	0
	Valley	5,076	1,290	21	0	27	0	48	0	48
II	Alexandria	6,110	1,853	71	2	6	0	77	2	79
	Arlington	8,826	1,220	7	0	0	3	7	3	10
	Fairfax-Falls Church	47,270	5,655	510	110	194	49	704	159	863
	Loudoun	10,229	1,679	67	15	1	0	68	15	83
	Prince William	17,219	3,020	19	0	2	0	21	0	21
III	Alleghany-Highlands	1,048	207	0	0	0	0	0	0	0
	Blue Ridge	11,000	1,460	53	0	31	0	84	0	84
	Central Virginia	10,484	1,354	0	0	1	0	1	0	1
	Cumberland Mountain	4,497	1,334	272	14	64	0	336	14	350
	Danville-Pittsylvania	4,907	1,437	27	5	33	3	60	8	68
	Dickenson County	739	244	0	0	0	0	0	0	0
	Highlands	3,122	1,542	0	3	0	1	0	3	3
	Mount Rogers	5,454	715	92	2	4	0	96	2	98
	New River Valley	7,518	1,459	36	2	141	0	177	2	179
	Piedmont	6,320	831	4	1	20	10	24	11	35
	P.D. 1	4,242	1,348	104	1	46	0	150	1	151
IV	Chesterfield	12,548	1,250	184	31	66	3	250	34	284
	Crossroads	4,479	550	3	0	3	0	6	0	6
	District 19	7,705	1,101	1	1	0	0	1	1	2
	Goochland-Powhatan	1,968	193	18	1	5	1	23	2	25
	Hanover	4,228	561	8	1	0	0	8	1	9
	Henrico	13,491	2,697	59	3	5	0	64	3	67
	Richmond Behavioral	8,835	2,298	16	28	46	9	62	37	99
	Southside	3,964	323	0	0	0	0	0	0	0
V	Chesapeake	9,414	1,290	42	6	1	0	43	6	49
	Colonial	6,275	954	155	12	8	0	163	12	175
	Eastern Shore	2,347	257	0	0	0	0	0	0	0
	Hampton-Newport News	14,804	1,574	0	0	0	0	0	0	0
	Middle Pen.-Northern Neck	6,151	1,516	15	3	19	4	34	7	41
	Norfolk	10,657	2,810	64	0	26	49	90	49	139
	Portsmouth	4,461	1,066	10	0	2	0	12	0	12
	Virginia Beach	19,511	553	1	0	146	0	147	0	147
	Western Tidewater	5,882	1,220	50	0	46	0	96	0	96
	TOTAL	335,545	53,854	2,011	255	981	142	2,992	397	3,389

Appendix G

Proposed State Facility Capital Priority Listing 2006-2012

<u>Project Title</u>	<u>Estimated Cost</u>
<u>2006-08</u>	
DMHMRSAS – Maintenance Reserve	7,135,000
DMHMRSAS – Roof Replacement	8,537,000
DMHMRSAS – Repair/Replace Infrastructure	4,778,000
DMHMRSAS – Food Service Renovations	14,380,000
DMHMRSAS – Boiler/Steamlines HVAC	10,021,000
DMHMRSAS – Abate Environmental Hazards (mold)	3,556,000
Southside Virginia Training Center – Renovate Bldg. 125	3,016,000
Southeastern Virginia Training Center – Construct Replacement Facility	75,431,213
Community Housing for Southeastern Virginia Training Center	11,864,301
Northern Virginia Training Center – Renovate and Construct Replacement Facility	81,747,820
Community Housing for Northern Virginia Training Center	14,788,415
Southwestern Virginia Training Center – Construct Replacement Facility	71,486,695
Community Housing for Southwestern Virginia Training Center	11,775,370
Hiram W. Davis Medical Center – Building Renovation	6,196,000
Southwestern Virginia Mental Health Institute – Renovations to Create Treatment Mall	5,576,000
Western State Hospital – Construct Replacement Facility	71,915,600
Community Housing for Western State Hospital in HPR 1	13,987,278
Community Housing for Western State Hospital in HPR 2	<u>20,054,412</u>
<i>Subtotal</i>	<i>\$436,246,104</i>
<u>2008-10</u>	
Central Virginia Training Center – Construct Replacement Facility	\$196,686,624
Eastern State Hospital - Construct Replacement Adult Mental Health Facility	\$55,167,000
Central State Hospital – Construct Replacement Facility	\$91,450,000
Southside Virginia Training Center – Construct Client Activity Center	<u>\$19,217,000</u>
<i>Subtotal</i>	<i>\$362,520,624</i>
<u>2010-12</u>	
Northern Virginia Mental Health Institute – New Administration and Parking Building	\$17,244,000
Piedmont Geriatric Hospital – Renovate Main Hospital Building	\$30,827,528
Southern Virginia Mental Health Institute – Renovate Main Hospital Building	\$8,887,000
Catawba Hospital – Renovate Main Hospital Building	<u>\$18,287,500</u>
<i>Subtotal</i>	<i>\$75,246,028</i>
Grand Total	\$833,075,652

Appendix H

Glossary of Department of Mental Health, Mental Retardation, and Substance Abuse Services and Services System Terms and Acronyms

<u>Acronym/Term</u>	<u>Name</u>
AA	Alcoholics Anonymous
AAMR	American Association on Mental Retardation
ABS	Adaptive Behavior Scale (MR)
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act (U.S.)
ADA	Assistant Director Administrative (DMHMRSAS state facility position)
ADC	Average Daily Census
ADRDA	Alzheimer's Disease and Related Disorders Association
ADSCAP	AIDS Control and Prevention Project
AHCPR	Agency for Health Care Policy and Research
AHP	Advocates for Human Potential
AITR	Agency Information Technology Resource
ALF	Assisted Living Facility (formerly Adult Care Residence)
ALOS	Average Length of Stay
AMA	Against Medical Advice
AOD	Alcohol and Other Drugs
AODA	Alcohol and Other Drug Abuse
APA	Administrative Process Act (Virginia)
APA	American Psychiatric Association
APA	American Psychological Association
AR	Authorized Representative
Arc of Virginia	Association for Retarded Citizens of Virginia
ARR	Annual Resident Review
ASAM	American Society of Addiction Medicine
ASFA	Adoption and Safe Families Act of 1997 (U.S.)
ASI	Addiction Severity Index
AT	Assistive Technology
ATOD	Alcohol, Tobacco and Other Drugs
ATTC	Addiction Technology Transfer Center
AVATAR	State Facility Information Patient/Billing System (DMHMRSAS hospital billing system that replaced PRAIS)
AWOP	Absent Without Permission
BHA	Behavioral Health Authority
C&A	Child and Adolescent
CAFAS	Child and Adolescent Functional Assessment Scale
CAPTA	Child Abuse Prevention Treatment Act
CARF	Commission on Accreditation of Rehabilitation Facilities
CARS	Community Automated Reporting System (DMHMRSAS)
CASA	National Center on Addiction and Substance Abuse at Columbia University

CASSP	Child and Adolescent Service Systems Program
CCCA	Commonwealth Center for Children and Adolescents (DMHMRSAS facility located in Staunton)
CCS	Community Consumer Submission (Community Information Extract Software)
CELT	Consumer Education and Leadership Training
CH	Catawba Hospital (DMHMRSAS facility located near Salem)
CHAP	Child Health Assistance Program
CHRIS	Comprehensive Human Rights Information System (DMHMRSAS)
CLAS	Culturally and Linguistically Appropriate Services (standards)
CM	Case Management
CMHS	Center for Mental Health Services (U.S.)
CMS	Centers for Medicare and Medicaid Services (U.S.)
CO	Central Office (DMHMRSAS)
Coalition	Coalition for Mentally Disabled Citizens of Virginia
COBRA	Comprehensive Omnibus Budget Reconciliation Act (also OBRA)
CODIE	Central Office Data and Information Exchange (DMHMRSAS Intranet)
COPN	Certificate of Public Need
COSIG	Co-Occurring State Incentive Grant
COY	Commission on Youth (Virginia)
CPI	Consumer Price Index
CPMT	Community Policy and Management Team
CRC	Commitment Review Committee
CRF	Classification Rating Form (MH-Adult)
CRIPA	Civil Rights of Institutionalized Persons Act (U.S.)
CSA	Comprehensive Services Act for Troubled Children and Youth (Virginia)
CSAO	Consortium of Substance Abuse Organizations (Virginia)
CSAP	Center for Substance Abuse Prevention (U.S.)
CSAT	Center for Substance Abuse Treatment (U.S.)
CSB	Community Services Board
CSH	Central State Hospital (DMHMRSAS facility located in Dinwiddie)
CSP	Community Support Program
CSQMC	Clinical Services Quality Management Committee (DMHMRSAS)
CSS	Community Support System
CVTC	Central Virginia Training Center (DMHMRSAS facility located near Lynchburg)
DAD Project	Discharge Assistance and Diversion Project (Northern Virginia)
DAP	Discharge Assistance Project
DARC	Division of Administration and Regulatory Compliance (DMHMRSAS Central Office)
DCS	Division of Community Services (DMHMRSAS Central Office)
DCHVP	Domiciliary Care for the Homeless Veterans Program
DCJS	Department of Criminal Justice Services (Virginia)
DD	Developmentally Disabled or Developmental Disabilities
DDHH	Department for the Deaf and Hard of Hearing (Virginia)
DFA	Division of Financial Administration (DMHMRSAS Central Office)
DFM	Division of Facility Management (DMHMRSAS Central Office)

DHCD	Department of Housing and Community Development (Virginia)
DHHS	Department of Health and Human Services (U.S.) (or HHS)
DHQC	Division of Health and Quality Care (DMHMRSAS Central Office)
DI	Departmental Instruction
DJJ	Department of Juvenile Justice
DMAS	Department of Medical Assistance Services (Virginia)
DMHMRSAS	Department of Mental Health, Mental Retardation and Substance Abuse Services (Virginia)
DOC	Department of Corrections (Virginia)
DOE	Department of Education (Virginia)
DOJ	Department of Justice (U.S.)
DPB	Department of Planning and Budget (Virginia)
DPSP	Division of Programs for Special Populations (U.S.)
DRGs	Diagnosis-Related Groups
DRS	Department of Rehabilitative Services (Virginia)
DSM-IV	Diagnostic and Statistical Manual (Mental Disorders), Fourth Edition
DVH	Department for the Visually Handicapped (Virginia)
EBP	Evidence-Based Practice
ECA	Epidemiologic Catchment Area
ECO	Emergency Custody Order
EI	Early Intervention
EIA	Early Intervention Assistance
EMTALA	Emergency Medical Treatment and Active Labor Act
EO	Executive Order
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
ESH	Eastern State Hospital (DMHMRSAS facility located in Williamsburg)
FAPT	Family Assessment and Planning Team
FAS	Fetal Alcohol Syndrome
FFP	Federal Financial Participation (Medicaid)
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FHA	Federal Housing Administration (U.S.)
FMLA	Family and Medical Leave Act
FMR	Fair Market Rent (U.S. Housing and Urban Development)
FMS - II	Financial Management System (DMHMRSAS)
FRP	Forensic Review Panel (DMHMRSAS)
FTE	Full Time Equivalent
FY	Fiscal Year (State)
GA	General Assembly (Virginia)
GAF	Global Assessment of Functioning
GOSAP	Governor's Office for Substance Abuse Prevention (Virginia)
HCB	Home and Community-Based (Medicaid MR Waiver)
HGTC	Hancock Geriatric Treatment Center (at Eastern State Hospital in Williamsburg)

HHR	Health and Human Resources Secretariat (Virginia)
HIE	Homeless Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HJR	House Joint Resolution (also HJ)
HMO	Health Maintenance Organization
HPR	Health Planning Region
HPSA	Health Professional Shortage Area
HRDM	Human Resources Development and Management Office (in DMHMRSAS Central Office)
HRIS	Human Resources Information System (DMHMRSAS)
HRSA	Health Resources and Services Administration (U.S.)
HSA	Health Services Area
HUD	Housing and Urban Development (U.S.)
HVAC	Heating, Ventilation, and Air Conditioning
HWDMC	Hiram W. Davis Medical Center (DMHMRSAS facility located in Dinwiddie)
I&R	Information and Referral
IAPSRs	International Association of Psychosocial Rehabilitation Services
ICD	International Classification of Diseases
ICES	Integrated Client Events System (DMHMRSAS)
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICT	Intensive Community Treatment
IDEA	Individuals with Disabilities Education Act (U.S.)
ILPPP	University of Virginia Institute of Law, Psychiatry and Public Policy
IMD	Institution for the Mentally Disabled (CMS term)
IM&R	Illness Management and Recovery
ISP	Individualized Services Plan
IP	Inpatient
IPA	Independent Practice Association
IQ	Intelligence Quotient
IS	Information Systems
ISP	Integrated Strategic Plan
ISN	Integrated Service Network
IT	Information Technology
JAIBC	Juvenile Accountability Incentive Block Grant (federal block grant)
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCHC	Joint Commission on Health Care
JJDPA	Juvenile Justice Delinquency Prevention Act (U.S.)
LEAP	Leadership-Empowerment-Advocacy Program
LEP	Limited English Proficiency
LGD	Local Government Department (a type of CSB)
LHRC	Local Human Rights Committee
LICC	Local Interagency Coordinating Council (Part C)
LOF	Level of Functioning
LOS	Length of Stay

LSC	Life Safety Code
LTC	Long Term Care
MCH	Maternal and Child Health
MCO	Managed Care Organization
MDR	Multidrug-Resistant
Medicaid DSA	Medicaid Disproportionate Share Adjustments
Medicaid DSH	Medicaid Disproportionate Share Hospital
MedIs	Medicaid Information Systems Project
MESA	Mutual Education, Support, and Advocacy
MH	Mental Health
MHT SIG	Mental Health Transformation State Incentive Grant
MHA-V	Mental Health Association of Virginia
MHI	Mental Health Institute
MHPC	Mental Health Planning Council
MHPRC	Mental Health Policy Resource Center
MHSIP	Mental Health Statistics Improvement Program
MHWG	Mental Health Work Group (of the Northern Virginia Regional Partnership)
MIC	Maternal and Infant Care
Mid-ATTC	Mid Atlantic Addiction Technology Transfer Center
MI/MR	Mental Illness/Mental Retardation (dual diagnosis)
MI/SA	Mental Illness/Substance Abuse (dual diagnosis)
MMWR	Morbidity and Mortality Weekly Report
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MR	Mental Retardation
MR/MI	Mental Retardation/Mental Illness (dual diagnosis)
MR Waiver	Medicaid Mental Retardation Home and Community-Based Waiver
MUA	Medically Underserved Area
NA	Narcotics Anonymous
NADD	National Association for the Dually Diagnosed
NAEH	National Alliance to End Homelessness
NAFARE	National Association for Family Addiction, Research and Education
NAMI	National Alliance for the Mentally Ill
NAMI -VA	National Alliance for the Mentally Ill - Virginia
NAPH	National Association of Public Hospitals
NAPWA	National Association of People with AIDS
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASDDDS	National Association of Directors of Developmental Disabilities Services
NASMPD	National Association of State Mental Health Program Directors
NASTAD	National Alliance of State and Territorial AIDS Directors
NCADD	National Council on Alcoholism and Drug Dependence
NCADI	National Clearinghouse for Alcohol and Drug Information
NCSACW	National Center for Substance Abuse and Child Welfare

NCCAN	National Center on Child Abuse and Neglect
NCH	National Coalition for the Homeless
NCS	National Comorbidity Survey
NCSACW	National Center for Substance Abuse and Child Welfare
NF	Nursing Facility
NGF	Non-general Funds
NGRI	Not Guilty by Reason of Insanity
NHCHC	National Health Care for the Homeless Council
NHIS-D	National Health Interview Survey Disability Supplement
NHSDA	National Household Survey on Drug Abuse
NIAAA	National Institute on Alcohol and Alcohol Abuse (U.S.)
NIDA	National Institute on Drug Abuse (U.S.)
NIH	National Institutes of Health (U.S.)
NIMH	National Institute on Mental Health (U.S.)
NVMHI	Northern Virginia Mental Health Institute (DMHMRSAS facility located in Falls Church)
NVTC	Northern Virginia Training Center (DMHMRSAS facility located in Fairfax)
OAE	Office of Architectural and Engineering Services (DMHMRSAS Central Office)
OAG	Office of the Attorney General (Virginia)
OAS	Office of Administrative Services (DMHMRSAS Central Office)
OB	Office of Budget and Financial Reporting (DMHMRSAS Central Office)
OBRA	Omnibus Budget Reconciliation Act of 1989 (U.S.)
OBS	Organic Brain Syndrome
OCAR	Office of Cost Accounting and Reimbursement (DMHMRSAS Central Office)
OCC	Office of Community Contracting (DMHMRSAS Central Office)
OFRC	Office of Financial Reporting and Compliance (DMHMRSAS Central Office)
OFS	Office of Forensic Services (DMHMRSAS Central Office)
OFS	Office of Financial and Grants Management (DMHMRSAS Central Office)
OHR	Office of Human Rights (DMHMRSAS Central Office)
OIA	Office of Internal Audit (DMHMRSAS Central Office)
OIG	Office of the Inspector General (Virginia)
OIM	Office of Investigations Management (DMHMRSAS Central Office)
OITS	Office of Information Technology Services (DMHMRSAS Central Office)
OL	Office of Licensing (DMHMRSAS Central Office)
OLIS	Office of Licensing Information System (DMHMRSAS)
OLPR	Office of Legislation and Public Relations (DMHMRSAS Central Office)
OMHRC	Office of Minority Health Resource Center (U.S.)
OMHS	Office of Mental Health Services (DMHMRSAS)
OMRS	Office of Mental Retardation Services (DMHMRSAS Central Office)
ONAP	Office of National AIDS Policy (U.S.)
OPD	Office of Planning and Development (DMHMRSAS Central Office)
OQI	Office of Quality Improvement (DMHMRSAS Central Office)
OQM	Office of Quality Management (DMHMRSAS Central Office)
OP	Outpatient

ORLA	Office of Risk and Liability Affairs (DMHMRSAS Central Office)
OSAS	Office of Substance Abuse Services (DMHMRSAS Central Office)
OSHY	Outreach Services for Homeless Youth
OT	Occupational Therapy
OUR	Office of Utilization Management (DMHMRSAS Central Office)
PACCT	Parents and Children Coping Together
PACT	Program of Assertive Community Treatment
PAIMI	Protection and Advocacy for Individuals with Mental Illnesses Act (U.S.)
PAIR	Parents and Associates of the Institutionalized Retarded
Part C	Part C of the IDEA (Federal funds for early intervention services)
PASARR	Pre-Admission Screening/Annual Resident Review
PATH	Projects for Assistance in Transition from Homelessness (federal grant)
PBPS	Performance-Based Prevention System
PBS	Positive Behavioral Supports
PEATC	Parent Educational Advocacy Training Center
PGH	Piedmont Geriatric Hospital (DMHMRSAS facility located in Burkeville)
PHA	Public Health Association
PHS	Public Health Service (U.S.)
PHWG	Private Hospital Work Group (of the Northern Virginia Regional Partnership)
PIP	Program Improvement Plan
PKI	Public Key Infrastructure
PL	Public Law (U.S.)
PMPM	Per Member Per Month
POIS	Purchase of Individualized Services
Pony Walls	Half-Height Walls in State Facility Patient Living Areas
POS	Purchase of Services
PPAC	Prevention and Promotion Advisory Council
PPC	Patient Placement Criteria
PPEA	Public Private Educational and Infrastructure Act of 2002 (Virginia)
PPO	Preferred Provider Organization
PPW	Pregnant and Postpartum Women
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (U.S)
PRAIS	Patient Resident Automated Information System (DMHMRSAS)
PRC	Perinatal Resource Center
PSR	Psychosocial Rehabilitation
PT	Physical Therapy
PTSD	Post Traumatic Stress Disorder
PWA	Persons with AIDS
QA	Quality Assurance
QI	Quality Improvement
QMHP	Qualified Mental Health Professional
QMRP	Quality Mental Retardation Professional
REACH	Recovery, Education and Creative Healing

Region I	Northwest Virginia
Region II	Northern Virginia
Region III	Far Southwestern Virginia
Region IV	Central Virginia
Region V	Eastern Virginia
Region VI	Southside Virginia
Region VII	Catawba Virginia
RM	Risk Management
RPAC	Restructuring Policy Advisory Committee (Virginia)
SA	Substance Abuse
SAARA	Substance Abuse and Addiction Recovery Alliance
S+C	Shelter Plus Care
SACAVA	Substance Abuse Certification Alliance of Virginia
SAMHSA	Substance Abuse and Mental Health Services Administration (U.S.)
SANAP	Substance Abuse Needs Assessment Project
SAPT	Substance Abuse Prevention and Treatment (Block Grant)
SDLC	System Development Life Cycle
SE	Supported Employment
SEC	State Executive Council (of Comprehensive Services Act)
SED	Serious Emotional Disturbance
SEVTC	Southeastern Virginia Training Center (DMHMRSAS facility located in Chesapeake)
SGF	State General Funds
SHRC	State Human Rights Committee
SJR	Senate Joint Resolution (also SJ)
SMHA	State Mental Health Authority
SMI	Serious Mental Illness
SMSA	Standard Metropolitan Statistical Area
SNF	Skilled Nursing Facility
SPMI	Serious and Persistent Mental Illness
SPO	State Plan Option (Medicaid)
SRO	Single Room Occupancy
SRO	School Resource Officer
SSA	Social Security Administration (U.S.)
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
State Board	State Mental Health, Mental Retardation and Substance Abuse Services Board
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder (Alcohol or other drug dependence or abuse)
SVMHI	Southern Virginia Mental Health Institute (DMHMRSAS facility located in Danville)
SVP	Sexually Violent Predator
SVTC	Southside Virginia Training Center (DMHMRSAS facility located in Dinwiddie)
SWG	Structural Work Group (of the Northern Virginia Regional Partnership)
SWVBHB	Southwest Virginia Behavioral Health Board

SWVMHI	Southwestern Virginia Mental Health Institute (DMHMRSAS facility located in Marion)
SWVTC	Southwestern Virginia Training Center (DMHMRSAS facility located in Hillsville)
TANF	Temporary Assistance for Needy Families (federal block grant)
TADBHAC	Terrorism and Disaster Behavioral Health Advisory Council
TB	Tuberculosis
TBI	Traumatic Brain Injury
TC	Training Center (state mental retardation facility)
TDO	Temporary Detention Order
TEDS	Treatment Episode Data Set
TFSASO	Task Force on Substance Abuse Services for Offenders (Virginia)
TIP	Treatment Improvement Protocols (CSAT)
TRW	Transition to Reinvestment Workgroup (of the SWVBHB)
TWWIIA	Ticket to Work and Work Incentives Improvement Act of 1999
UAI	Uniform Assessment Instrument
UM	Utilization Management
UR	Utilization Review
URICA	University of Rhode Island Change Assessment
VAADAC	Virginia Association of Alcoholism and Drug Abuse Counselors
VACSB	Virginia Association of Community Services Boards
VACO	Virginia Association of Counties
VADAP	Virginia Association of Drug and Alcohol Programs
VAHA	Virginia Adult Home Association
VAHMO	Virginia Association of Health Maintenance Organizations
VALHSO	Virginia Association of Local Human Services Officials
VANHA	Virginia Association of Nonprofit Homes for the Aging
VASAP	Virginia Alcohol Safety Action Program (Commission on)
VASH	Veterans Administration Supported Housing
VATTC	Virginia Addictions Technology Transfer Center
VBPD	Virginia Board for People with Disabilities
VCBR	Virginia Center for Behavioral Rehabilitation (DMHMRSAS facility in Petersburg)
VDEM	Virginia Department of Emergency Management
VDMDA	Virginia Depressive and Manic-Depressive Association
VEC	Virginia Employment Commission (Virginia)
VHHA	Virginia Hospital and Healthcare Association
VHCA	Virginia Health Care Association
VHDA	Virginia Housing Development Authority (Virginia)
VHST	Virginia Human Services Training Center
VICC	Virginia Interagency Coordinating Council
VIACH	Virginia Interagency Action Council on Homelessness
VICH	Virginia Interagency Council on Homelessness
VIPACT	Virginia Institute for Professional Addictions Counselor Training
VITA	Virginia Information Technologies Agency
VITC	Virginia Intercommunity Transition Council

VML	Virginia Municipal League
VNPP	Virginia Network of Private Providers
VOCAL	Virginia Association of Consumers Asserting Leadership
VOPA	Virginia Office for Protection and Advocacy
VPCA	Virginia Primary Care Association
VPN	Virtual Private Network
VR	Vocational Rehabilitation
VRHRC	Virginia Rural Health Resource Center
WIB	Workforce Investment Board
WRAP	Wellness Recovery Action Plan
WSH	Western State Hospital (DMHMRSAS facility located in Staunton)

Appendix I

Comprehensive State Plan 2006-2012 Reference Documents

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